Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** VERYL MORGAN 02 11:18 18 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Year) Jul 20, 193 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)

PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Min. Months 215-36-9771 Director 73 1934 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits MD Allegany Cresaptown 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13527 Fir Tree Lane 21502 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ Xo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 laborer Wilson Welding Co 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Robossen Morgan Charlotte Susan Miller Morgan ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13527 Fir Tree Lane Shirley Morgan wife MD 21502 Cresaptown permit. Pages 1 and:
Department of Health
Important: if item 27
any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Park 2/22/2008 4 □ Donation 5 □ Other (Specify) Cumberland MD 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Ligensee 108 Virginia Avenue: Cumberland, MD 21502 1. 5 fer the disease, by a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, synck, or heart failure. List in ly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 266HC Physician Shoc days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Bilateral pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Physician/Medical Examiner burial-trar Due to (or as a consequence of): the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an cate has to page 2 s autopsy 2.2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3 DOA 1 Inpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Box 68760, Division or Vital Records, P.O. Hospital or Attending Physician:

Saltimore, Maryland 21215-0036

To the room within 24 hours after room To the Funeral Director. After room and release in by the funeral process.

Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

WONSOCK SHINMO 31. Date filed (Month, Day, Year)

· worsochofhin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925

BISHOPWALSH RD CUMBERLAND MD 21502

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00055325

29d. Date signed (Month, Day, Year)

Feb 18,2008

32. Registrar's Signature

| Funeral Director  Funeral Dire | c. County of Death Prince George's  //DD/YYYYY 9. Birthplace (State or Foreign Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |  |
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| Manifer   Mani   | c. County of Death Prince George's  //DD/YYYY)  9. Birthplace (State or Foreign Country) Massachusetts  10d. Inside City Limits 1 X Yes 2 No  izen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White  Kind of Business/Industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  |  |
| Funeral Director  Funeral Director  Funeral Director  Figure 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Prince George's    Indicate   Prince George's     Indicate   Prince George's     Indicate   Prince George     Indicate   Indicate     Indicate   Indic |  |  |  |  |  |  |  |  |  |  |
| Social Security Number   6. Sex   7. Age (in yrs. last birthday)   1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | //DD/YYYY)  9. Birthplace (State or Foreign Country)  Massachusetts  10d. Inside City Limits  1 X Yes 2 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |  |
| Director    O17-18-4130                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10d. Inside City Limits 1 X Yes 2 No lizen of What Country? USA  14. Race - American Indian, Black, White, etc.  Specify: White Kind of Business/Industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  |  |
| Usual Residence of Decedent   10a. State   10b. County   Maryland   Prince George's   Greenbelt   10a. State   10b. County   Maryland   Prince George's   10c. City, Town or Location   County   10b. City   10b. Ci   | 10d. Inside City Limits 1 X Yes 2 No lizen of What Country? USA  14. Race - American Indian, Black, White, etc.  Specify: White Kind of Business/Industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  |  |
| 10a. State   10b. County   10c. City, Town or Location   10c. Ci   | 1 X Yes 2 No lizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White  Kind of Business/Industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  |  |
| 1   Yes   2   No   Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | USA  14. Race - American Indian, Black, White, etc.  Specify: White Kind of Business/Industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  |  |
| 1   Yes   2   No   Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | USA  14. Race - American Indian, Black, White, etc.  Specify: White Kind of Business/Industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  |  |
| 1   Yes   2   No   Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 14. Race - American Indian, Black, White, etc.  Specify: White Kind of Business/Industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |  |
| 1   Yes   2   No   Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | White, etc.  Specify: White  Kind of Business/Industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |  |
| 1   Yes   2   No   Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Kind of Business/Industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee    22. Name and Address of Facility   24 / Casch's Funeral Home, P.A. Hy   23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Kind of Business/Industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  |  |
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| Physician  Medical  Wedical  A Constance  Masch  Gasch's Funeral Home, P.A. Hy  Physician  Medical  Casch's Funeral Home, P.A. Hy  Physician  Casch's Funeral Home, P.A. Hy  Casch's Funer | 739 Baltimore Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  |  |
| failure. List only one cause on each line.  Hypertensive Atherosclerotic Cardiovascular Disease  Hypertensive Atherosclerotic Cardiovascular Disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | yattsville, MD 20781                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  |  |
| Medical  Hypertensive Atherosclerotic Cardiovascular Disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Between Onset and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |  |
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| Or condition resulting in death)  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |  |
| if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |  |
| events resulting in death) Last Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |  |
| So a gradual property of the state of the st | 3d. Date of delivery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  |  |
| FEMALE:   23c. If yes, outcome of pregnancy   1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Month Day Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |  |
| Yes 2 No 9 Unknown 1 Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |  |
| O the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | to use contribute to the cause of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |  |
| Out the second s | No 3 Probably 4 ✔ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?  1  Yes 2  25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  27. Manner of Death  28a. Date of Injury  28b. Time of Injury 28c. Injury at Work?  28d. Describe how in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 24b. Were autopsy findings available<br>prior to completion of cause of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |  |
| performed? 1 ▼ Yes 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |  |
| The state of Death (Check only one)  1 ✓ Yes 2  25. Was case referred to medical examiner?  1 ✓ Yes 2  1 ✓ Yes 2  1 ✓ Yes 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence of Dother Nursing Home 5 Residence of | dence 6 Other: Scene                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  |  |
| 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how in 1 V Natural 5 Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how in 1 Ves 2 No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | njury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |  |
| O But the street of Death of Lorentz and the street of Loren | David David Number City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |  |
| 28. Place of Injury - At home, farm, street, factory, office building, etc.  28. Place of Injury - At home, farm, street, factory, office building, etc.  28. Place of Injury - At home, farm, street, factory, office building, etc.  28. Place of Injury - At home, farm, street, factory, office building, etc.  28. Place of Injury - At home, farm, street, factory, office building, etc.  28. Place of Injury - At home, farm, street, factory, office building, etc.  28. Place of Injury - At home, farm, street, factory, office building, etc.  28. Place of Injury - At home, farm, street, factory, office building, etc.  28. Place of Injury - At home, farm, street, factory, office building, etc.  28. Place of Injury - At home, farm, street, factory, office building, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | t and Number or Rural Route Number, City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |  |
| Pending Investigation  Accident  Suicide  Accident  Suicide  Accident  Suicide  Accident  Suicide  Could not be determined  Could not be determine | and manner as stated                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one) 29m Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | place, and due to the cause(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |  |
| and manner stated.  29b. Signature and title of certifier  29c. License number  29d.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | d. Date signed (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |  |
| O.C.M.E. Fe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |  |
| 30. Name/and address of person who completed cause of death (Item 23a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ebruary 7, 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |  |
| Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ebruary 7, 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |  |
| State 31. Date filed (Month, Day Year) 32. Registrar's Signature  Registrar FFB 1 2 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ebruary 7, 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |  |

DHMH 17 Rev 1/2001 OCME 2006

| 08-010 | 1057<br>ald Moore |  |
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| Donald | Moore             |  |

| nald Moore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | State of Maryland / Department of Health and Mental For State  Certificate of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | -lygiene<br>Reg.              | No. 200                          | 8 0600                                               |
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| Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | egistrar<br>Decedent's Name (First, Middle,Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Date of Death     Month     I | Day Year                         | 3. Time of Death                                     |
| edical Examine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                | Donald Vincent Moore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | February 6,                   | 2008                             | 0746 hrs                                             |
| }                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4              | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ath                           | 4c. County of Death              |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | Baltimore Washington Medical Center Glen Burnie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | Anne Arundel                     |                                                      |
| Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 5              | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               | (MM/DD/YYYY) 9. Birtl<br>Foreign | nplace (State or                                     |
| Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | 216-90-5241   1 x M 2 F   42 Yrs.   Months   Days   Hours   M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <sup>fin.</sup> 11/05/        | 1965 Co.                         | Maryland                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | Jsual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                               |                                  |                                                      |
| any                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | _              | 10a. State 10b. County 10c. City, Town or Location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               |                                  | 10d. Inside City Limits                              |
| <b>*</b> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | MD Anne Arundel Odenton                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               |                                  | 1 X Yes 2 No                                         |
| Maryland<br>28a-f show<br>d at once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 밁              | 10e. Street and Number 10f. Zip Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 100                           | g. Citizen of What Cour          | ntry?                                                |
| th the Ma<br>23a or 28<br>notified                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Director       | 837 Sunny Chapel Road 21113                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 3                             |                                  | USA                                                  |
| ith th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                | 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               |                                  | can Indian, Black,                                   |
| ath w<br>items                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Funeral        | 1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Pue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | erto Rican, etc.)             | White, etc.                      |                                                      |
| er de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               | Specify: W                       | hite                                                 |
| urs afi<br>tural                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ദ⊢             | 15 Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               | 16b. Kind of Business/           | ndustry                                              |
| 2 hou "mail "mail                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ᇎ              | Elementary/Secondary (0-12) College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | retired)                      |                                  |                                                      |
| )36<br>hin 7<br>e.<br>than                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | mpleted        | 12 Electrician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               | Private                          |                                                      |
| d with                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ᇬ              | 17. Father's Name (First, Middle, Last) 18. Mother's Na                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ame (First, Middle, M         | laiden Surname)                  |                                                      |
| 21215-0036 Juld be filed within 77 Mental Hygiene marked other than c event, the Medica                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Be (           | Donald W. Moore Doroth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ny E. Tear                    | 10                               |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2              | 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | or Rural Route Num            | ber, City or Town, State         | e, Zip Code)                                         |
| MD d 2 sho lith and n 27 is aumati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | Danica Moore/ Wife 837 Sunny Chapel Rd.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               |                                  |                                                      |
| e, N<br>I and<br>Healt<br>item                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Date                          | 20c. Location - City or          | Town, State                                          |
| OC<br>ages<br>at of<br>t: If                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | - 1            | 1 X Burial 2 Cremation 3 Removal from State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 2/12/2008                     | Brentwood                        | MD                                                   |
| Baltimore, semit. Pages 1 ar Jepartment of Her Important: If ite Injury or other tr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                | 4 Donation 5 Other Specify Ft. Lincoln Cemetery 102 21. Signature of Funeral Service 22. Name and Address of Facility I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Fort Linco                    | ln Funeral                       | Home                                                 |
| Ba<br>Perm<br>Depa<br>Impe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 23             | 3/01 Bladenshurg                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | RD Bren                       | twood. MD                        | 20722                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | +              | Author the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinates the death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ac or respiratory arre        | est, shock, or heart             | Approximate Interval<br>Between Onset and            |
| Physician / ical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               |                                  | Death                                                |
| aminer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1              | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               |                                  | 1                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | - 1            | h                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               |                                  |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 힐              | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                               |                                  |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 盲              | Compared to sufficiently larger to the compared to sufficient and sufficient to suffic |                               |                                  |                                                      |
| asit ed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Examiner       | events resulting in death) Last  Due to (or as a consequence or).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               |                                  |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | UNPENDED AMENDED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                               |                                  |                                                      |
| O, the expectation is be expected by the control of | edical         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | 23d. Date of delive              | rv                                                   |
| Box 6876( death certificate the attending phy ed for use as the t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | sician/M       | IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | egnancy                       | Month                            | Day Year                                             |
| certi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <u>ë</u> .     | past 12 months?  4 Pregnant at time of death 5 Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               | 1                                |                                                      |
| 30X<br>death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ysi            | 1 Yes 2 No 9 Unknown g Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               |                                  |                                                      |
| C. By the ached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | F              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               | obacco use contribute t          |                                                      |
| rres that the signed by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | þ              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1Ye                           | s 2 🗸 No 3 🗌 Pr                  |                                                      |
| Division of Vital Records, ria for Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Completed      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 24a. Was<br>autor             |                                  | autopsy findings available<br>completion of cause of |
| SOF<br>law r<br>has b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 힐              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | rmed? death?                     |                                                      |
| The Trace                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | હ              | 25. Was case referred to medical 26. Place of Death (Ch                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               | 2NO                              | 163                                                  |
| certif                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Be             | 20. Was case released to medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Jursing Home 5                | Residence 6 Oth                  | ner:                                                 |
| of VI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ٤              | 1 V Yes 2 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               | how injury occurred              |                                                      |
| n of ing P                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               | ,,                               |                                                      |
| ior<br>trend<br>death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | i<br>High      | Periodical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               | Street and Number or             | Rural Route Number, City                             |
| ivision or Attendafter death Director:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 띭              | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | or Town,                      | State)                           | Adrai Rodio Hambor, Orty                             |
| Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physompletely filled in by the funeral director, page 2 should be detached for use as the b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Certification: | 4 Homicide determined (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | -                             |                                  |                                                      |
| To the Hospital<br>within 24 hours<br>completely filled                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the property of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place of the property of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place of the property of the pasts of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place of the pasts of | e, and due to the cau         | se(s) and manner as st           | ated.<br>the cause(s)                                |
| o the athin o the smple                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Medical        | one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | med at the time, date         |                                  |                                                      |
| H % H %                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ğ              | 29b. Signature and title of certifier 29c. License number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                               | 29d. Date signed (A              |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | Come MU incenti, MID O.C.M.E.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                               | February 7, 20                   | U8                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 30. Name and address of person who completed cause of death (Item 23a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                               |                                  |                                                      |
| RU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | e, MD 21201                   |                                  |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ate            | 20 Designatoria Signatura                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                               |                                  |                                                      |
| - J                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1.11.77        | FER 1 2 2008 Keeping & Appendix                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                  |                                                      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) Year Day Month 3:30P M February 3, 2008 McIntyre Andrea 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince George's Upper Marlboro 9805 Rosaryville Road If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex Days Months 1 ☐ M 2 🛛 F 27, 1949 Washington, DC 58 Sept. 577-66-7528 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 1 TYYes 2 No Maryland | Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 20772 United States 9805 Rosaryville Road Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Management Analyst Government 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theresa Peyton Clinton O. McIntyre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9805 Rosaryville Rd. Upper Marlboro, MD 20772 Diane J. McCallum - Sister Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 9, 2008 Suitland, MD Lincoln Mem. Cemt. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sid ature of Funeral Seri 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 Years Ovarian Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

**Physician** /Medical Examiner

certificate be executed

P.O. Box 68760,

Division or Vital Records,

Attending Physician:

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If fleen 27 is marked othe any Injury or other traumatic event, once.

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

ဥ

**Funeral** 

Director

be filed within 72 hours after death with the Maryland ral Hygiene.

1 other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notifiled at

Baltimore, Maryland 21215-0036

for use as the burial-trans and nding physiciar sate has been signed by the a page 2 should be detached certificate

funeral director this After ours after death.
neral Director: /
filled in by the fu death. ō

within 24 hours a

To the Funeral I

completely filled State Registrar

Hospital

Examine Physician/Medical þ Completed 25. Was case referred to medical Be Medical Certification: To 27. Manner of Death

IF FEMALE: 23b. Was decedent pregnant

1 ☐ Yes 2 ☐ No

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only

4 Homicide

autopsy performed? ∕es **2**☐ No 1∐ Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Hospital: 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check onl one

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of centifier

6 Could not be determined

29c. License number MD33253

29d. Date signed (Month, Day, Year) February 7, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan A. Cosin, MD 110 Irving St., NW #5B-33B Washington, DC 20010

31. Date filed (Month, Day, Year) FEB 12

32. Registrar's Sign ture

and manner stated.

Registrar

State

30. Name and address of per

Date filed (Month, Day,

3

2008

eted cause of death (Item 23a) (Type, Print)

|                                                                                                                                                                                                                                                        |                 | 1                 | For State                                                                                                                    | aryland / Depa<br><i>Cer</i>                      | artment of H<br>rtificate of L                                  |                                               | ental Hygien<br>Reg. N                       |                                        | 06006                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------|----------------------------------------------|----------------------------------------|--------------------------------------------------------|
|                                                                                                                                                                                                                                                        |                 | _                 | Registrar  1. Decedent's Name (First, Middle, Last)                                                                          |                                                   |                                                                 |                                               | 2. Date of Death                             | av Year                                | 3. Time of Death                                       |
|                                                                                                                                                                                                                                                        | sicia<br>ledica | al                | Patricia Ann Moo                                                                                                             | re                                                |                                                                 |                                               |                                              | 3 2008                                 |                                                        |
|                                                                                                                                                                                                                                                        | amine           |                   | 4a. Facility Name (If not institution, give street and number)                                                               | Center                                            |                                                                 | Location of Death                             | 4                                            | c. County of Dea                       | •                                                      |
| Fune                                                                                                                                                                                                                                                   | eral            |                   | 5. Social Security Number 6. Sex 7. Ag                                                                                       | e (In yrs. last birthday)                         | If Under 1 Year<br>Months Days                                  | If Under 24 Hrs.<br>Hours Min.                | 8. Date of Birth<br>(Month, Day, Yea         | (r) Go                                 | thplace (State or Foreign<br>ountry)                   |
| Direc                                                                                                                                                                                                                                                  | tor             |                   | 218-20-4841 1 M (2 M F ) Usual Residence of Decedent                                                                         | 80 YIS.                                           |                                                                 |                                               | 3/10/192                                     | 7   Ma                                 | ryland                                                 |
| ryland<br><b>how</b>                                                                                                                                                                                                                                   | # F             |                   | 10a. State 10b. County                                                                                                       | 10c. City, Town or Lo                             |                                                                 |                                               |                                              |                                        | 10d. Inside City Limits 1 XYes 2 No                    |
| ne Ma                                                                                                                                                                                                                                                  | otified         | ecto              | Maryland Wicomico                                                                                                            | Salisbu                                           | 10f, Zip Code                                                   |                                               | 10a (                                        | Citizen of What Co                     |                                                        |
| with ti                                                                                                                                                                                                                                                | u eq            |                   | 10e. Street and Number<br>1514 Riverside Dr., Apt.                                                                           | 204B                                              | 21801                                                           | _                                             |                                              | USA                                    | ,                                                      |
| Daltiffilore, intal yialing 2 12 13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show | er mus          | Funeral Director  | 11. Marital Status 12. Was Decedent Armed Forces?                                                                            | Ever in U.S. 13.                                  | Was Decedent of H<br>If Yes, specify Cuba                       | ispanic Origin? (Spe<br>an, Mexican, Puerto F | cify Yes or No-<br>Rican, etc.)              | 14. Race - Ame<br>Black, Whi           |                                                        |
| hours afte                                                                                                                                                                                                                                             | Examin          | <u>ک</u>          | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:                                                        | No                                                | 1 □ Yes 2 □XNo                                                  | Specity:                                      |                                              | Specify: W                             | hite                                                   |
| 72 ho                                                                                                                                                                                                                                                  | edical          | Completed         | 15. Decedent's Education (Specify only highest grade completed)                                                              | (Give                                             | dent's Usual Occup<br>kind of work done o<br>DO NOT use retired | ation<br>during most of workin<br>d)          | 16b.                                         | Kind of Business                       | /Industry                                              |
| withir liene.                                                                                                                                                                                                                                          | the M           | dwo               | Elementary/Secondary (0-12) College (1-4or s                                                                                 | 5+)                                               | s clerk                                                         | <u> </u>                                      | i                                            | etail                                  |                                                        |
| d be filed<br>ental Hyg                                                                                                                                                                                                                                | went,           | Bec               | 17. Father's Name (First, Middle, Last)                                                                                      |                                                   |                                                                 |                                               | (First, Middle, Maid<br>erce Bost            |                                        |                                                        |
| arylario 2<br>should be filed and Mental Hygics<br>s marked other                                                                                                                                                                                      | natic e         | 횬.                | Julian Brannock  19a. Informant's Name/Relationship (Type. Print)                                                            | 19h Maili                                         | no Address /Street                                              | and Number or Rura                            |                                              |                                        | Zip Code)                                              |
| and 2 shealth and n 27 is n                                                                                                                                                                                                                            | r traun         |                   | William R. Moore Jr/son                                                                                                      | 17 S                                              | Squirrel I                                                      | Lane, Newa                                    | rk, DE 19                                    | 711                                    |                                                        |
| Pages 1 annent of Hee                                                                                                                                                                                                                                  | or othe         |                   | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State                                                   | 20b. Place of Dispo<br>cemetery, cre<br>Springh   | osition (Name of<br>ematory or other place<br>111 Memor         | ce)<br>V                                      |                                              | . Location - City o                    | r Town, State                                          |
| altification mit. Pages partment of portant: If it                                                                                                                                                                                                     | njury           | 1                 | 4 □ Donation 5 □ Other (Specify)  21. Separature of Funeral Service Licensee                                                 | Gardens                                           |                                                                 | 2/12                                          |                                              | ebron, M                               | D<br>Association                                       |
| balt<br>permit.<br>Departr<br>Imports                                                                                                                                                                                                                  | any Ir          |                   | David H. Compsor                                                                                                             |                                                   |                                                                 | Hill Rd.,                                     |                                              |                                        |                                                        |
|                                                                                                                                                                                                                                                        |                 |                   | 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on                   |                                                   |                                                                 |                                               |                                              | `                                      | Approximate<br>Interval Between<br>Onset and Death     |
| Physic                                                                                                                                                                                                                                                 |                 |                   | Immediate Cause (Final disease or condition a.                                                                               | 24/1                                              | BOCTAGE                                                         | (2/                                           | Threfo                                       | · · · · ·                              | dy                                                     |
| /Med<br>Exami                                                                                                                                                                                                                                          |                 |                   | Due to (or as                                                                                                                | a c nsequence of):                                |                                                                 | ,                                             |                                              |                                        | 97                                                     |
|                                                                                                                                                                                                                                                        |                 | Jer               | Se uentially list conditions, it any, leading to immediate cause. Enter I leading a                                          | a consequence of).                                |                                                                 |                                               |                                              |                                        | 1                                                      |
| ecuted                                                                                                                                                                                                                                                 | transit         | Examin            | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | s a consequence of):                              |                                                                 |                                               |                                              |                                        |                                                        |
| cate be executed physician and                                                                                                                                                                                                                         | burial          |                   | Due to (or as                                                                                                                | s a consequence or.                               |                                                                 |                                               |                                              |                                        |                                                        |
| <b>55/</b> tifficate g phys                                                                                                                                                                                                                            | as the          | ledic             | 0                                                                                                                            |                                                   |                                                                 |                                               |                                              |                                        |                                                        |
| <b>BOX 6</b> leath certific attending p                                                                                                                                                                                                                | or use          | Physician/Medical |                                                                                                                              | 2 Fetal death 3                                   | □Ectopic pregnanc                                               | у                                             |                                              | 23d. Date of d<br>Month                | elivery<br>Day Year                                    |
| at the dea<br>by the at                                                                                                                                                                                                                                | shed fo         | ysici             | 1 ☐ Yes 2 ZNo 9 ☐ Unknown                                                                                                    | at time of death 5                                | Other (specify) _                                               |                                               |                                              |                                        |                                                        |
| that the                                                                                                                                                                                                                                               | detac           |                   | Part II. Other significant conditions contributing to death                                                                  | but not resulting in the u                        | underlying cause giv                                            | ven in Part I.                                | 23e. Did tobacc                              |                                        | to the cause of death?                                 |
| ords<br>equires<br>en sign                                                                                                                                                                                                                             | should be deta  | ed by             |                                                                                                                              |                                                   |                                                                 |                                               | 1 ☐ Yes                                      | 2 No 3                                 | Probably 4 2 Unknown                                   |
| I KECOTGS, P.O. BOX 68/6U,  The law requires that the death certificate be executed ate has been signed by the attending physician and                                                                                                                 | e 2 sh          | Completed         |                                                                                                                              |                                                   |                                                                 |                                               | 24a. Was an autopsy performed                | prior to                               | autopsy findings available<br>o completion of cause of |
| VITAL F<br>sician: The<br>certificate                                                                                                                                                                                                                  | or, pag         |                   | 25. Was case referred to medical                                                                                             |                                                   |                                                                 | 26 Place of Deatl                             | 1 Yes 2 ☐                                    |                                        |                                                        |
| ysicial<br>ysicial                                                                                                                                                                                                                                     | directo         | To Be             | examiner?  1 Yes 2 No Hospital: Input                                                                                        | tient 2 ER/Outpatie                               | ent 3 DOA Oth                                                   | hor                                           | me 5 Residence                               | e 6 □Other (Sp                         | pecify)                                                |
| ng Ph<br>fter thi                                                                                                                                                                                                                                      | neral (         |                   | 27. Manner of Death 28a. Date of In (Month, D                                                                                |                                                   | Wo                                                              | rk?                                           | 28d. Describe how i                          | injury occurred                        |                                                        |
| DIVISION OF<br>lor Attending Physafter death.<br>Director: After this                                                                                                                                                                                  | the fu          | icatio            | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of its                                                     | njury - At home, farm, s                          |                                                                 | Yes 2 No                                      | 28f. Location (Stree                         | et and Number or                       | Rural Route Number,                                    |
| DIV<br>all or A                                                                                                                                                                                                                                        | d in by         | Certification:    | 4 Homicide determined building, 6                                                                                            | etc. (Specify)                                    |                                                                 |                                               | City or Town, S                              | State)                                 |                                                        |
| DIVISION OF VITAL HEQ<br>To the Hospital or Attending Physician: The law<br>within 24 hours after death. To the Funeral Director: After this certificate has                                                                                           | ely fille       |                   | 29a. Certifler (Check only)  Certifying Physician: To the bes 2 Medical Examiner: On the basis                               | of examination and/or i                           | ath occurred at the t<br>investigation, in my                   | time, date and place,<br>opinion, death occur | and due to the caus<br>red at the time, date | se(s) and manner<br>e and place, and d | as stated.<br>ue to the cause(s)                       |
| thin 24                                                                                                                                                                                                                                                | mplet           | Medical           | one) and mariner s                                                                                                           | stated.                                           |                                                                 |                                               |                                              |                                        |                                                        |
| ~ ~                                                                                                                                                                                                                                                    | 8               |                   | D A A A                                                                                                                      |                                                   | D 20                                                            | 1441                                          |                                              | 02/081                                 | 2008                                                   |
| 190                                                                                                                                                                                                                                                    | h               |                   | 30. Name and address of person who completed cause of                                                                        | death (Item 23a) (Type  100 E.  strar's Signature | e, Print)                                                       | - / -                                         | //                                           | 1-1                                    | 2.60 1                                                 |
|                                                                                                                                                                                                                                                        |                 |                   | 31 Date filed (Month, Day, Year) 32. Regis                                                                                   | Strar's Signature                                 | CARROLL                                                         | 5t. SA                                        | 115 buny                                     | Md.                                    | 21801                                                  |
| ∜<br>Re                                                                                                                                                                                                                                                | Sta<br>egist    |                   | FFB 1 2 2008                                                                                                                 | ou the                                            | Carrie .                                                        |                                               |                                              |                                        |                                                        |

|                               |                                                                                                                                                                                                                                                                                      |                | For State                                                                                           | State                                               | of Marylan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                 | artmeni<br>rtificate                    |                    |               | and M           | ental Hy                   | 0                        | 2008                      |                        | 16008                              | 3        |
|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------|--------------------|---------------|-----------------|----------------------------|--------------------------|---------------------------|------------------------|------------------------------------|----------|
|                               | _                                                                                                                                                                                                                                                                                    |                | Registrar  1. Decedent's Name (First, Middle                                                        | e, Last)                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 | rimoan                                  | J 01 L             | - Cairi       |                 | 2. Date of De              | Reg. Ng.                 | . 000                     | ,                      | 3. Time of Death                   |          |
|                               | Physicia                                                                                                                                                                                                                                                                             |                | Geraldine Loui                                                                                      |                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |                                         |                    |               |                 | Month<br>Februa            | Day<br>arv 1             | 7, 200                    |                        | 4:08 P                             | М        |
|                               | /Medic<br>Examin                                                                                                                                                                                                                                                                     |                | 4a. Facility Name (If not institution                                                               |                                                     | ımber)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <del></del>                     | 4b. City,                               | Town, or           | Location of   | of Death        |                            |                          | County of De              |                        |                                    |          |
|                               | Examin                                                                                                                                                                                                                                                                               |                | Oakland Nursin                                                                                      | g & Rehab                                           | ilitatio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | on                              | 0ak]                                    | Land               |               |                 |                            | G                        | arrett                    |                        |                                    |          |
|                               | Funeral                                                                                                                                                                                                                                                                              |                | 5. Social Security Number                                                                           | 6. Sex<br>1 ☐ M 2 ☐ XF                              | 7. Age (In yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | last birthday)                  | If Under<br>Months                      | 1 Year<br>Days     | If Under      | 24 Hrs.<br>Min. | 8. Date of Bi<br>(Month, D | ay, Year)                |                           | Birthplac<br>Country   | e (State or Forei                  | 'gn      |
| L                             | Director                                                                                                                                                                                                                                                                             |                | 170-24-2048                                                                                         | 1   M 2   10 P                                      | 78                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Yrs.                            |                                         | - /-               |               |                 | April                      | 28 1                     | 929 1                     | enn                    | sylvania                           | <u>a</u> |
|                               | and<br>W                                                                                                                                                                                                                                                                             |                | Usual Residence of Decedent  10a. State 10b. County                                                 |                                                     | 10c. Cit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ty, Town or Lo                  | ocation                                 |                    |               |                 |                            |                          |                           | 10d                    | . Inside City Limit                | ts       |
|                               | f sho                                                                                                                                                                                                                                                                                | ō              | MD Gar                                                                                              | rett                                                | O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | akland                          |                                         |                    |               |                 |                            |                          |                           |                        | 1 X Yes 2 □ N                      | 10       |
|                               | the 288                                                                                                                                                                                                                                                                              | Directo        | 10e. Street and Number                                                                              | 1000                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | antuna                          | 10f. Zip                                | Code               |               |                 |                            | 10g. Citi                | zen of What               | Country                | ?                                  |          |
|                               | h with                                                                                                                                                                                                                                                                               | 0              | 706 E. Alder S                                                                                      | treet                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 | 215                                     | 550                |               |                 |                            | Unit                     | ed Sta                    | ates                   |                                    |          |
|                               | deet                                                                                                                                                                                                                                                                                 | Funeral        | 11. Marital Status                                                                                  | 12. Was Dec                                         | cedent Ever in U                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | .S. 13.                         | Was Deced                               | dent of His        | spanic Ori    | igin? (Spe      | cify Yes or N              | 0-                       | 14. Race - Al<br>Black, W |                        |                                    |          |
| 9                             | or Its                                                                                                                                                                                                                                                                               |                | 1 Never Married 2 Mar                                                                               | If Yes, G                                           | orces?<br>2 2 No<br>ive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                 | 1 ☐ Yes                                 |                    | Specity:      |                 | ,                          |                          | Specify:                  |                        |                                    |          |
| Ö                             | filed within 72 hours after deeth with the Maryland<br>Hygiene.<br>Ither than "natural; or Items 23a or 28a-( show<br>ent, the Medical Examinar must be notified a                                                                                                                   | d by           | 3 ☐ Widowed 4 🕅 Divorced                                                                            |                                                     | Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 16a Dasa                        | dentis Linus                            | l Ossum            | ation         |                 |                            | 16h Ki                   | M<br>nd of Busine         | nite                   |                                    |          |
| 15                            | n 72<br>"nat                                                                                                                                                                                                                                                                         | Completed      | (Specify only highe                                                                                 | it's Education<br>st grade completed                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (Give                           | dent's Usua<br>kind of wor<br>DO NOT us | rk done d          | lurina mos    | t of worki      | ng                         | IOD. KI                  | nd of busine              | ss/IIIuu:              | stry                               |          |
| 2                             | within then                                                                                                                                                                                                                                                                          | E O            | Elementary/Secondary (0-12)                                                                         | College                                             | (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Home                            | emake                                   | r                  |               |                 |                            | C                        | wn Hor                    | ne                     |                                    |          |
| 0                             | other<br>other                                                                                                                                                                                                                                                                       | Be C           | 17. Father's Name (First, Middle,                                                                   | Last)                                               | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 |                                         |                    | 18. Mothe     | er's Name       | (First, Middle             | , Maiden                 | Sumame)                   |                        |                                    |          |
| <u>a</u>                      | should be f<br>and Mental h<br>marked of<br>umatic eve                                                                                                                                                                                                                               | To B           | Herbert Cletus                                                                                      | Shive                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |                                         |                    | F1o           | renc            | e Anni                     | e But                    | cher                      |                        |                                    |          |
| a                             | es 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hygiene. If term 27 is marked other than "natural; or Items 23a or 28a-1 show item 27 is marked other than "natural; or item 27 is more ovent, the Madical Examinar must be notified at |                | 19a. Informant's Name/Relations                                                                     | ship (Type, Print)                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 19b. Maili                      | ing Address                             | (Street a          | and Numbe     | er or Rura      | l Route Numb               | er, City o               |                           |                        |                                    |          |
| Σ                             | and and a                                                                                                                                                                                                                                                                            |                | Brenda Durose,                                                                                      | Daughter                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |                                         |                    | -             |                 | Beaver                     | ,                        |                           | 2301                   |                                    |          |
| altimore, Maryland 21215-0036 | of Hora                                                                                                                                                                                                                                                                              |                | 20a. Method of Disposition 1 ☐ Burial 2 X Cremation                                                 | 3 □Removal from                                     | State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Place of Dispo<br>cemetery, cre |                                         |                    |               |                 | ate                        | 20c. Lo                  | cation - City             | or Town                | n, State                           |          |
| Ě                             | Pag<br>ment<br>tant:                                                                                                                                                                                                                                                                 |                | 4 Donation 5 Other (5                                                                               | Specify)                                            | Cui                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | mberla                          |                                         |                    | -             |                 |                            |                          | berla                     | _                      | MD                                 |          |
| Bail                          | permit. Pages 1<br>Department of H<br>Important: If Ite<br>eny injury or ot                                                                                                                                                                                                          |                | 21. Signature of Funeral Service                                                                    | Licensee                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2                               | 2. Name an<br>David                     | Addres             | s of Facility | ck F            | uneral                     | Home                     | P.A                       | •                      |                                    |          |
|                               | 00300                                                                                                                                                                                                                                                                                |                | 23a. Part 1. Enter the disease, o                                                                   | A WELTY                                             | anyond the deat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |                                         |                    |               |                 | Oaklan                     |                          | 21550                     | 1                      | pproximate                         |          |
|                               |                                                                                                                                                                                                                                                                                      |                | shock, or heart failure. Lis                                                                        | only one cause on                                   | each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | / 0 0                           | ter the mod                             |                    | y, such as    | cardiac         | ii ioapiiatory             | arrest,                  |                           | l lr                   | nterval Between<br>Inset and Death |          |
| }                             | Physician<br>/Medical                                                                                                                                                                                                                                                                |                | Immediate Cause (Final disease or condition resulting in death)                                     | a                                                   | ir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | flee                            | nza                                     | 1                  |               |                 |                            |                          |                           | -                      | lweek                              |          |
| П                             | Examiner                                                                                                                                                                                                                                                                             |                |                                                                                                     | Due to                                              | o (or as a conseq                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Juence of):                     | 0                                       |                    |               |                 |                            |                          |                           |                        |                                    |          |
|                               |                                                                                                                                                                                                                                                                                      | e              | Sequentially list conditions, if any, leading to immediate                                          | b. — Due to                                         | (or as a consec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | quence of):                     |                                         | -                  |               |                 |                            |                          |                           |                        |                                    |          |
|                               | uted<br>d<br>ansit                                                                                                                                                                                                                                                                   | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | <b>S</b> .                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |                                         |                    |               |                 |                            |                          |                           |                        |                                    |          |
| ó                             | s be executed<br>sicien and<br>burial-transit                                                                                                                                                                                                                                        | Exa            | resulting in death) Last                                                                            | Due to                                              | o (or as a consec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | quence of):                     |                                         |                    |               |                 |                            |                          |                           |                        |                                    |          |
| 8760,                         | The law requires that the death certificate be executed ate has been signed by the attending physicien and agge 2 should be detached for use as the burial-transit                                                                                                                   | dical          |                                                                                                     | d                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |                                         |                    |               |                 |                            |                          |                           | 4                      |                                    |          |
| 9                             | eath certifici<br>attending pl                                                                                                                                                                                                                                                       | Med            | IF FEMALE:                                                                                          |                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |                                         |                    | -             |                 |                            |                          |                           |                        |                                    |          |
| Box                           | ath co                                                                                                                                                                                                                                                                               | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?                                                   | 1 ☐ Live                                            | utcome of pregna                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | al death 3                      | □Ectopic p                              |                    |               |                 |                            | 1                        | 23d. Date of<br>Month     |                        | ay Year                            |          |
| o<br>O                        | the a                                                                                                                                                                                                                                                                                | ysic           | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown                                                                       | 4⊟Preg<br>9⊟Unk                                     | gnant at time of one of the communication of the co | seath 5                         | Other (sp                               | оеспу)             |               |                 |                            |                          |                           |                        |                                    |          |
| ۵.                            | w requires that the de<br>been signed by the<br>should be detached                                                                                                                                                                                                                   |                | Part II, Other significant conditi                                                                  | ons contributing to                                 | death but not res                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | sulting in the I                | underlying o                            | ause give          | en in Part I  | 1.              | 23e. Did                   | tobacco u                | use contribute            | e to the               | cause of death?                    |          |
| g                             | uires<br>sign<br>d be                                                                                                                                                                                                                                                                | d by           | Schisox                                                                                             | shrevia                                             | he                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1 Der                           | tens                                    | ion                |               |                 | 1□                         | Yes 2                    | □ No 3 □                  | Probab                 | oly 4 Minknov                      | wn       |
| Records,                      | w req                                                                                                                                                                                                                                                                                | Completed      | 0.1                                                                                                 |                                                     | /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 |                                         | •                  |               |                 | 24a. Wa                    |                          | 24b. Were                 | autops                 | y findings availal                 | ble      |
| Re                            | he lay<br>e has<br>age 2                                                                                                                                                                                                                                                             | E              |                                                                                                     |                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |                                         |                    |               |                 | per                        | opsy<br>formed?          | death                     | to comp<br>1?<br>/es 2 | oletion of cause o                 | of       |
| ta                            | ilcian: Th<br>certificate<br>rector, pag                                                                                                                                                                                                                                             | BeC            | 25. Was case referred to medical                                                                    | at                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |                                         |                    | 26. Place     | e of Death      | 1 ☐ Yes<br>Check only      | -                        |                           | 2                      |                                    |          |
| <u>=</u>                      | yslci<br>is cer<br>direct                                                                                                                                                                                                                                                            | To B           | examiner?<br>1 ☐ Yes 2 ☑ No                                                                         | Hospital: 1                                         | Inpatient 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ] ER/Outpatie                   | ent 3 🗆 DC                              | Othe               | [             |                 | me 5□Res                   |                          | 6 □Other (S               | Specify)               |                                    |          |
| 0                             | ding Phys<br>h.<br>After this<br>funeral di                                                                                                                                                                                                                                          |                | 27. Manner of Death 1 ANatural 5 ☐ Pendi                                                            |                                                     | e of Injury<br>onth, Day Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 28b. Time o                     | of 2                                    | 28c. Injun<br>Worl | at /          |                 | 28d. Describe              | how injur                | y occurred                |                        |                                    |          |
| <u>ö</u>                      | Attending Physician: r death. sctor: After this certifics by the funeral director; s                                                                                                                                                                                                 | atle           | 2 Accident invest                                                                                   | igation                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 | М                                       |                    | Yes 2 □       |                 |                            |                          |                           |                        |                                    |          |
| Division of Vital             | l or Attendater deatl<br>Director:<br>I in by the                                                                                                                                                                                                                                    | Certification: | 3 Suicide 6 Could 4 Homicide deter                                                                  | nined 200. Flat                                     | ce of Injury - At h<br>ding, etc. (Speci                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                 | treet, factor                           | y, office          |               |                 |                            | (Street an<br>own, State |                           | r Aurai i              | Route Number,                      |          |
|                               | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page                                                                                                     |                | 29a. Certifier                                                                                      | na Obvejejani Ta V                                  | ha ha at at any lan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                 | Ab 4                                    |                    | data as       | nd alass        | and due to th              | (2)                      | ) and magne               |                        | lad                                |          |
|                               | To the Hospital within 24 hours a To the Funeral I completely filled                                                                                                                                                                                                                 | edical         |                                                                                                     | ng Physician: To to<br>f Examiner: On the<br>and ma | basis of examination                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ation and/or i                  | nvestigation                            | in my o            | pinion, dea   | ath occurr      | ed at the time             | e, date and              | d place, and              | due to t               | he cause(s)                        |          |
|                               | omple<br>omple                                                                                                                                                                                                                                                                       | Me             | 29b. Signature and title of certifi                                                                 | ər                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1                               | 29                                      | c. License         | e number      |                 |                            | 29d. Da                  | te signed (M              | onth, D                | ay, Year)                          |          |
| )                             | > - 0                                                                                                                                                                                                                                                                                |                | > 1/1/12 an                                                                                         | vot 10.                                             | Kin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 11                              |                                         | D                  | 261           | 650             |                            | 2-                       | 17-                       | 20                     | 08                                 |          |
|                               |                                                                                                                                                                                                                                                                                      | -4-            | 30. Name and address of person                                                                      | who completed ca                                    | use of death (Ite                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | m 23a) (Type                    | Print)                                  | _ال                | 0 144         |                 |                            | -                        | 1                         | 1-                     | 08                                 |          |
|                               |                                                                                                                                                                                                                                                                                      | 3              | margaretak                                                                                          | aiser r                                             | nd, 132                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                 | errett                                  | his                | nual          | 4               | oakl                       | and                      | -MS                       | ) 2                    | 1530                               |          |
|                               | Sta                                                                                                                                                                                                                                                                                  |                | 31. Date filed (Month, Day, Year                                                                    |                                                     | Registrar's Sign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ature                           | 1 1                                     |                    | 1             | ı               |                            |                          |                           |                        |                                    |          |
|                               | Regist                                                                                                                                                                                                                                                                               | ral r          | FFB 1                                                                                               | 9 2008                                              | MARCHARLO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Ry. B                           |                                         | F                  |               |                 |                            |                          |                           |                        |                                    |          |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** P M STANLEY C MAZALESKI FEBRUARY 08 2008 3:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 1, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 ☐ F 184-32-1361 74 1933 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Maryland Frederick Emmitsburg Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2035 Pembrook Court 21727 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Korea 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Environmental Toxicologist U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Mazaleski Esther Johnson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte B. Mazaleski, wife 2035 Pembrook Court, Emmitsburg, MD 21727 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State New St. Joseph's Cem 2/13/2008 Emmitsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License 210 W. Main Street, Emmitsburg, MD 21727 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a, Part1 Immediate Cause (Final disease or condition resulting in death) gocardial **Physician** Acute Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the court of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be def þ ndron 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No DOMA 24a. Was an certificate has autopsy ANGXIX ENC 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division or Vital Records, P.O. Box 68760, 24 hours after death.

Funeral Director: After this filled in by within 24

> WIL btIVA State Registrar

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 1 1

62

aNRI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MD

egistrar's Signature

Frederica

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MD 51610

21702

29d. Date signed (Month, Day, Year)

M. TOLING, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Oscar Page Mawyer 9. /Medical February 2008 11:03 ÅM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil <u>Elkton</u> Ceci1 Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**∑**M 2□F Months Hours Director Nov. 15, 1931 Virginia 230-30-8823 76 death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 28a-f show 1 Yes 2 No Maryland Ceci1 Directo E1kton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21 Leedom Road 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examliner. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Municipal Elementary/Secondary (0-12) College (1-4or 5+) Fireman Fire Department 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Emmett Mawyer Etta (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy Mawyer / Spouse 21 Leedom Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State February 1€ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 7 5 ☐ Other (Speeny) Hopewell Cemetery 12, 2008 Port Deposit, Maryland 22. Name and Address of Facility Crouch Funeral Home 21. Signature Functial S lut 127 South Main Street, North east, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ordrac unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to for as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 2 KER/Outpatient 3 □ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death To the Funeral Director:

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32 Begistrar's Signature

DHMH 17 Rev 1/2001

00060756

29d. Date signed (Month, Day, Year)

w Main St. Elkbon, mo 21921

# Marjorie R. MileS Baltimore, Maryland 21215-0036

|                |                                                                                                                                                                                                                                           |                   | Plea                                                                                                        | se Type or Pri                                       |                         |                |                                                     |                                            | •                                           |               | gible.                         |                                                    |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------|----------------|-----------------------------------------------------|--------------------------------------------|---------------------------------------------|---------------|--------------------------------|----------------------------------------------------|
|                |                                                                                                                                                                                                                                           |                   | For State                                                                                                   | State of M                                           | aryland /               |                | artment of F<br>r <i>tificate of</i>                | lealth and N                               | , ,                                         | 0             | 000                            | ocoll                                              |
| - 4            |                                                                                                                                                                                                                                           | -                 | 1 - State Registrar  1. Decedent's Name (First, Middle)                                                     | e, Last)                                             |                         | Cei            | lilicate of                                         | Dealli                                     | 2. Date of Deat                             | eg. No.       | UUU                            | 3. Time of Death                                   |
| H              | Physici<br>/Medic                                                                                                                                                                                                                         |                   | Marjorie R. Mil                                                                                             |                                                      |                         |                |                                                     |                                            | Februar                                     | Day           | Year 2008                      | 8:18 PM                                            |
|                | Examin                                                                                                                                                                                                                                    |                   | 4a. Facility Name (If not institution                                                                       | n, give street and number)                           | 0 /                     | ^              | 4b. City, Town, c                                   | or Location of Death                       |                                             | 4c. Cou       | inty of Death                  | ,                                                  |
|                |                                                                                                                                                                                                                                           |                   | 5. Social Security Number                                                                                   | ledical<br>6. Sex 7. As                              | ge (In yrs. last bi     | RK<br>irthday) | If Under 1 Year                                     | ata<br>If Under 24 Hrs.                    | 8. Date of Birth                            |               | har (                          | Q S                                                |
| b              | Funeral Director                                                                                                                                                                                                                          |                   | 579-20-9001                                                                                                 | 1□M 2 <b>X</b> F                                     | 83                      | Yrs.           | Months Days                                         | Hours Min.                                 | 8. Date of Birth<br>(Month, Day,<br>0ct. 20 | , 192         | 4 I 11                         | place (State or Foreign<br>ntry)<br>inois          |
|                | pu ,                                                                                                                                                                                                                                      |                   | Usual Residence of Decedent  10a. State 10b. County                                                         |                                                      | 10c. City, Tov          | vn or Lo       | cation                                              |                                            |                                             |               |                                | 10d. Inside City Limits                            |
|                | Maryla<br>f shovied at                                                                                                                                                                                                                    | 0                 | Maryland Char                                                                                               | loc                                                  | Waldo                   |                |                                                     |                                            |                                             |               |                                | XXYes 2 □ No                                       |
|                | r 28a-                                                                                                                                                                                                                                    | Director          | 10e. Street and Number                                                                                      | 162                                                  | waluu                   |                | 10f. Zip Code                                       |                                            | 1                                           | 0g. Citizen   | of What Cour                   | ntry?                                              |
|                | tth witt<br>23a o<br>ust be                                                                                                                                                                                                               | a<br>D            | 4859 Leonard                                                                                                | town Road                                            |                         |                | 206                                                 |                                            |                                             | USA           |                                |                                                    |
|                | er dea<br>items<br>ner m                                                                                                                                                                                                                  | Funeral           | 11. Marital Status                                                                                          | 12. Was Decedent<br>Armed Forces<br>ried 1 Tyes 2    | Ever in U.S.            |                |                                                     | Hispanic Origin? (Sp<br>an, Mexican, Puert | ecify Yes or No-<br>Rican, etc.)            |               | Race - Americ<br>Black, White, |                                                    |
| 336            | is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by F              | 1 □ Never Married 2 □ Mar<br>3 ◯ Widowed 4 □ Divorced                                                       | It Yes Give                                          | Íuo.                    |                | 1□Yes XXNo                                          | Specify:                                   |                                             | Spe           | ecify: Whi                     | te                                                 |
| 21215-0036     | 72 hou<br>natura<br>dical E                                                                                                                                                                                                               | Completed         | 15. Deceder<br>(Specify only highe                                                                          | t's Education<br>st grade completed)                 | 168                     | a. Dece        | dent's Usual Occup                                  | pation<br>during most of work<br>d)        | kina                                        | 16b. Kind o   | of Business/In                 | dustry                                             |
| 121            | within<br>ene.<br>than "                                                                                                                                                                                                                  | ld m              | Elementary/Secondary (0-12)                                                                                 | College (1-4or                                       | 5+)                     |                | DO NOT use retire<br>Other                          | d)                                         |                                             | 0             |                                |                                                    |
| d 2            | filed y                                                                                                                                                                                                                                   | Be Co             | 17. Father's Name (First, Middle,                                                                           | Last)                                                |                         | 1416           | o ther                                              | 18. Mother's Nam                           | ne (First, Middle, I                        |               | Home<br>mame)                  |                                                    |
| Maryland       | uld be<br>Mental<br>rked (                                                                                                                                                                                                                | To B              | William Frankl                                                                                              | ine Rule                                             |                         |                |                                                     | Lela                                       | Elizabe                                     | th Jo         | nes Ru                         | le                                                 |
| lan            | 2 sho<br>l and l<br>is ma                                                                                                                                                                                                                 |                   | 19a. Informant's Name/Relations                                                                             |                                                      |                         | b. Mailir      | ng Address (Street                                  | and Number or Ru                           | ral Route Number                            | r, City or To | wn, State, Zip                 | o Code)                                            |
|                | 1 and 2<br>Health<br>em 27                                                                                                                                                                                                                | 1                 | Jeannette Hoff 20a. Method of Disposition                                                                   | man/ Daughte                                         |                         | 01             | Sunset La<br>sition (Name of<br>matory or other pla | ane, Prin                                  | ce Frede                                    | rick,         | Mary Lon - City or To          | and, 20678<br>own State                            |
| Baltimore,     | 0 U L                                                                                                                                                                                                                                     |                   | 1 M Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (5                                                       |                                                      |                         |                |                                                     | ,                                          |                                             |               | •                              |                                                    |
| altii          | permit. Pag<br>Department<br>Important: I<br>any injury o                                                                                                                                                                                 | 19                | 21. Signature of Funeral Service                                                                            |                                                      | II La L                 | 22             | 2. Name and Addre                                   | ess of Facility                            | untt Fund                                   | erall         | Home                           | Maryland                                           |
| 8              | 9 4 E 8 9                                                                                                                                                                                                                                 | 0 0               | 12-121                                                                                                      |                                                      | 2921                    |                | •                                                   | Vashingto                                  |                                             |               | , MD. :                        |                                                    |
| B              |                                                                                                                                                                                                                                           |                   | 23a. Part1. Enter the disease, o<br>shock, or heart failure. List                                           | complications that cause<br>only one cause on each I | d the death. Do<br>ine. | not ent        | er the mode of dyi                                  | ng, such as cardiac                        | or respiratory arr                          | est,          |                                | Approximate<br>Interval Between<br>Onset and Death |
|                | Physician /Medical                                                                                                                                                                                                                        |                   | Immediate Cause (Final disease or condition resulting in death)                                             | a.                                                   | a consequence           | <b>PS</b>      | 12                                                  |                                            |                                             |               |                                |                                                    |
|                | Examiner                                                                                                                                                                                                                                  |                   |                                                                                                             | N.                                                   | ecro                    | 17             | ng                                                  | Cellul                                     | itis                                        |               |                                |                                                    |
|                | D #                                                                                                                                                                                                                                       | iner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as                                        | a consequence           | ul)O           |                                                     |                                            |                                             |               |                                |                                                    |
| _              | e executed<br>ian and<br>urial-transit                                                                                                                                                                                                    | Examiner          | that initiated events resulting in death) Last                                                              | c                                                    | a consequence           | of):           |                                                     |                                            |                                             |               |                                |                                                    |
| 760,           | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit                                                                                      |                   |                                                                                                             |                                                      |                         | ,-             |                                                     |                                            |                                             |               |                                |                                                    |
| 687            | leath certificate be<br>attending physici<br>I for use as the bu                                                                                                                                                                          | Physician/Medical |                                                                                                             | 0.                                                   |                         |                |                                                     |                                            |                                             |               |                                |                                                    |
| Box            | ath cer<br>ttendir<br>or use                                                                                                                                                                                                              | an/N              | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?                                          |                                                      | 2 Fetal deat            |                | Ectopic pregnanc                                    | :y                                         |                                             | 23d.          | Date of deliv                  | rery<br>Day Year                                   |
| O.             | the de<br>/ the a<br>ched f                                                                                                                                                                                                               | ysic              | 1 ☐ Yes 2 ☒ No<br>9 ☐ Unknown                                                                               | 4⊟Pregnant a<br>9⊟Unknown                            | at time of death        | 5 L            | Other (specify) _                                   |                                            |                                             |               |                                |                                                    |
| <u>α</u>       | ires that the de<br>signed by the a<br>be detached t                                                                                                                                                                                      | by Ph             | Part II. Other significant conditi                                                                          | ons contributing to death t                          | out not resulting       | in the u       | nderlying cause gi                                  | ven in Part I.                             | 23e. Did tol                                | bacco use     | contribute to t                | the cause of death?                                |
| Vital Records, | w require<br>been sig<br>should b                                                                                                                                                                                                         | ed b              |                                                                                                             |                                                      |                         |                |                                                     |                                            | 1 □ Y                                       | es 2 N        | lo 3□Pro                       | bably 4 ∐Unknown                                   |
| ecc            | has be                                                                                                                                                                                                                                    | Completed         |                                                                                                             |                                                      |                         |                |                                                     |                                            | 24a. Was a                                  | sy            | prior to co                    | opsy findings available<br>empletion of cause of   |
| al F           | Page T                                                                                                                                                                                                                                    |                   |                                                                                                             | . 1                                                  |                         |                |                                                     |                                            | perform<br>1□ Yes                           | med?<br>2 No  | death?<br>1 ☐ Yes              | 2 □ No                                             |
|                | Physician: this certific ral director,                                                                                                                                                                                                    | o Be              | 25. Was case referred to medica examiner?  1 ☐ Yes 2 ☐ No                                                   | Hospital: 1 Inpati                                   | ent 2 ER/O              | utoatier       | nt 3□ DOA Oti                                       | her                                        | th <i>(Check only on</i><br>ome 5 ☐ Reside  |               | Other (Speci                   | (fy.)                                              |
| n or           | ding Phy<br>h.<br>After thi<br>funeral (                                                                                                                                                                                                  |                   | 27. Manner of Death 1 X Natural 5 ☐ Pendir                                                                  | 28a. Date of Inj                                     | ury 28b.                | Time o         |                                                     |                                            | 28d. Describe ho                            |               | , ,                            |                                                    |
| Sio            | Attending<br>r death.<br>ector: After                                                                                                                                                                                                     | catic             | 2 Accident investi                                                                                          | gation                                               |                         |                | M 1                                                 | ]Yes 2□No                                  |                                             |               |                                |                                                    |
| Division       | l or Al<br>after o<br>Direc                                                                                                                                                                                                               | Certification:    | 4 Homicide determ                                                                                           | pined 28e. Flace of in                               | tc. (Specify)           | arm, sti       | reet, factory, office                               |                                            | City or Town                                |               | umber or Hur                   | al Route Number,                                   |
|                | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu                                                                                                                |                   | 29a. Certifier 1 Certifyii (Check only 2 Medical                                                            | ng Physician: To the best                            | of my knowledg          | je, deat       | h occurred at the t                                 | ime, date and place                        | , and due to the c                          | ause(s) and   | d manner as                    | stated.                                            |
|                | the Hin 24<br>the Fi                                                                                                                                                                                                                      | Medical           | one)                                                                                                        | Examiner: On the basis of and manner s               | tated.                  | ind/or in      |                                                     |                                            |                                             |               |                                |                                                    |
|                | No With                                                                                                                                                                                                                                   | 2                 | 29b. Signature and title of certifie                                                                        | ( Q ( ) M                                            |                         |                | 29c. Licen:                                         | se number                                  | ·- 7   2                                    | 9d. Date si   | igned (Month,                  | , Day, Year)                                       |
| 0              |                                                                                                                                                                                                                                           |                   | 30. Name and address of person                                                                              | who completed cause of                               | death (Item 23a)        | (Type.         | Print)                                              | 0010                                       | 0 304                                       | 4             | 11/2                           | - 0                                                |
| Y              | 85                                                                                                                                                                                                                                        |                   | Atul Katya                                                                                                  |                                                      |                         |                |                                                     | Sq.                                        | e 304                                       | orf.          | md.                            | 20603                                              |
| 8              | Sta<br>Registr                                                                                                                                                                                                                            |                   | 31. Date filed (Month, Day, Year,                                                                           | 32. Regist                                           | rar's Signature         |                | brook                                               | 1                                          |                                             |               |                                |                                                    |
| 14             | negisti                                                                                                                                                                                                                                   | aı                | 1101                                                                                                        | I 7000                                               | V6 10.                  | Jes J          |                                                     |                                            |                                             |               |                                |                                                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend 5, per FD, DOR, 2/15/08, LDB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month 2008 2:00 PM OWard /Medical 4a. Facility Name (If not institution, give street ar 4b. City, Town, or Location of Death 4c. County of Death Examiner TRAPPE
If Under 1 Year | If Under 24 Hrs. Old Trappe Talbot Road 5. Social Security Number 214-74-5486 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1925 Director APR:1 Maryland Usual Besidence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☑Yes 2 ☐ No Director Talbot Trappe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4865 USA 12. Was Decedent Ever in U.S. Armed Forces? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ⋧ 3 ☐ Widowed 4 ☑ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-employed arpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ္ larence 19a. Informant's Name/Relationship (Type. Print) 1865 Old trappe Road Trappe MΙ MD. 21673 arol 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State TRappe, Maryland aradise Cemetery 2/12/08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Henry Funeral Ton St. FUNDRAL anbridge MD, 21613 23a. Party Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each ine. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 TUnknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 1∐ Yes 26 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 5X Residence 6 ☐Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 22 Medical Examiner: On the basis of examination and/or investigation, in we spinon, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

2

State Registrar 31. Date filed (Month, Day, Year)

strar's Signature

M.D 4416 Backelons A. P. OKFORD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | = For State Registrame (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) Certificate of Death 2. Date of Death Marisol Jimenez February 2008 8:07 pM Rosa Mejia 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Nursing & Rehab. Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours Months Days 216-45-3304 1 M 2 2 6 1/rs. Nov. 30, 1946 Brazil Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Montgomery Marvland Silver Spring

Physician /Medical Examiner

Physician

/Medical

**Examiner** 

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760.

| 10s Chest and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| 11. Marital Status 1 □ Never Married ★★ Married                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 No                                                  | .S. 13. Wa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | as Decedent of l<br>es, specify Cub                  | Hispanic Origin? (<br>oan, Mexican, Pue                   | Specify Yes or Norto Rican, etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 10-                                                                     | 14. 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| 3 ☐ Widowed 4 ☐ Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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| 15. Decedent's Ed<br>(Specify only highest grade)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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Ki                                                                 | nd of Business/                      | Industry                                                                |
| Elementary/Secondary (0-12)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                      | 18. 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| 19a. Informant's Name/Relationship (7 Daniela X. 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| 20a. Method of Disposition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 20b. 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Lo                                                                 | cation - City or                     | Town, State                                                             |
| 1 ☑ Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| 21. Signature of Funeral Service Licen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | LCole                                                                                                        | Fra                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Name and Addr<br>ancis J<br>Unive:                   | . Collin:                                                 | s Funera                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | l Hor<br>Silve                                                          | me Inc.<br>er Spri                   | ng, MD 2090                                                             |
| 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                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| Immediate Cause (Final disease or condition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| if any, leading to immediate cause. Enter Underlying Cause (Ulsaase on Injury) that initiated events                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Due to (or as a consec                                                                                       | uence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                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                                                                                                                                                                                                                                                                                                                                                                              |                                                                         |                                      |                                                                         |
| IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 23c. If yes, outcome pf pregn<br>1 □ Live birth 2 □ Feta<br>4 □ Pregnant at time of o                        | al death 3 □E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ctopic pregnand                                      |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4                                                                       | 23d. Date of del<br>Month            | ivery<br>Day Year                                                       |
| 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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                                                                                                                                                                                                            | ( <del>-p</del>                                      |                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 9□Unknown                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                      |                                                           | 23e. Did                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | tobacco u                                                               | se contribute to                     | the cause of death?                                                     |
| 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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                                                                                                                                                                                                                                                                                                                                                                              | tobacco u                                                               |                                      | the cause of death?                                                     |
| 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 9□Unknown                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                      |                                                           | 1 24a. Wa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Yes 2<br>s an<br>opsy<br>formed?                                        | <b>©</b> No 3□Pr                     | obably 4 Unknown<br>utopsy findings available<br>completion of cause of |
| 1 □ Yes 2 □ No<br>9 □ Unknown  Part II. Other significant conditions of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 9⊡Unknown                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | erlying cause gi                                     | ven in Part I.  26. Place of De                           | 24a. Wa aut                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Yes 2<br>s an<br>opsy<br>formed?<br>2 X No                              | No 3 Pr                              | robably 4 Unknown utopsy findings available completion of cause of      |
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions of the conditions | 9□Unknown  ontributing to death but not res  Hospital: 1 □ Inpatient 2□                                      | ulting in the under                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | erlying cause gi                                     | ven in Part I.  26. Place of Deher:                       | 24a. Wa aut per                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | yes 2<br>s an<br>opsy<br>formed?<br>2 X No                              | 24b. Were au prior to death?         | obably 4 Unknown utopsy findings available completion of cause of 2 No  |
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions of the conditions | 9□Unknown  ontributing to death but not res  Hospital: 1□Inpatient 2□  28a. Date of Injury (Month, Day Year) | ulting in the unde                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | erlying cause gi                                     | ven in Part I.  26. Place of Deher:                       | 24a. Wa<br>aut<br>per<br>1 Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | s an opsy formed? 2 X No                                                | 24b. Were au prior to death? 1 □ Yes | obably 4 Unknown utopsy findings available completion of cause of 2 No  |
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions of the conditions | 9□Unknown  ontributing to death but not res  Hospital: 1□Inpatient 2□  28a. Date of Injury (Month, Day Year) | ulting in the under the un | 3 DOA Ot                                             | 26. Place of Deher:  4X Mursing                           | 24a. Wa aut per 1 Yes eath (Check only Home 5 Re: 28d. Describe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | s an opsy formed? 2 12 No rone) sidence (e how injur                    | 24b. Were at prior to death?  1      | obably 4 Unknown utopsy findings available completion of cause of 2 No  |
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions of examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death ※☑ Natural 5 ☐ Pending investigation 3 ☐ Suicide 4 ☐ Homicide  29a. Certifier 1 ☑ Certifying Ph.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 9□Unknown  ontributing to death but not res  Hospital: 1□Inpatient 2□  28a. Date of Injury (Month, Day Year) | ER/Outpatient 28b. Time of Injury ome, farm, stree                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | accurred at the terror cause gi                      | 26. Place of Deher:  AXMursing  rry at  rk?  ] Yes 2 □ No | 24a. Wa aptroper property of the property of t | s an opsy formed? 2 12 No one) sidence (Street an own, State e cause(s) | 24b. Were at prior to death?  1      | atopsy findings available completion of cause of 2 No city)             |

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 13

2008

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 3:50 AM February 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** OIN If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year Date of Birth (Month, Day, 5. Social Security Number 6. Sex Age (In vrs. last birthday) **Funeral** Min 1□M 2 Months Days Hours 11/06/1930 PA 162-22-7477 77 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19524 Meadowbrook Rd. 21742 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Maryland 21215-0036 Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 Is marked other than "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Health care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Etter LeRoy Jane ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ardinger 247 Garfield St. Chambersburg, PA 17201 Doris or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 4 Donation 5 Other (Specify) Lincoln Cemetery 1/18/2008 Chambersburg, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1001035 R.G. Sellers F.H. Inc. 297 Phila. Ave. Chambg. PA 17201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 No ed by the a 9 Tinknown 23e. Did tobacco use contribute to the cause of death? been signed the should be detected Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes No 24a. Was an has autops MAINTR 101 certificate Yes this certificate director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) √ Inpatient 2 ER/Outpatient 3□ DOA 2 1 Tes 28a Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After thi completely filled in by the funeral

95H-10

31. Date filed (Month, Day, Year) State FEB 15 Registrar

29a. Certifier

(Check only one)

Medical

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Ppint)

ERSONMOS

2008

32. Registrar's Signature

| Division or Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and | *                                          | ⊏Xã                                                                                                                          | IIIIII                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                          | Division or Vital Records, P.O. Box 68760, | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. | To the Funeral Director: After this certificate has been signed by the attending physician and |

|          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               | Please Type or Print                                                                                                                                |                                          |                                                          |                            |                                            |                                        |                                                  |
|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------|----------------------------|--------------------------------------------|----------------------------------------|--------------------------------------------------|
|          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1                             | For State Of Ma State Registrar                                                                                                                     | -                                        | epartment of F<br>Certificate of                         |                            |                                            | giene<br>Reg. No. 7 1 1 8              | 06017                                            |
|          | Physicia                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | an                            | Decedent's Name (First, Middle, Last)                                                                                                               |                                          |                                                          |                            | 2. Date of Dea                             | nth                                    | 3. Time of Death                                 |
|          | /Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | al                            | Wayne Elmer McAF  4a. Facility Name (If not institution, give street and number)                                                                    | EE                                       | 4b. City, Town, o                                        | or Location of Death       | Februar                                    | y 10, 2008<br>4c. County of Dea        | 8:47 AM                                          |
|          | Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | er                            | 1033 Main Avenue                                                                                                                                    |                                          | Hagers                                                   | town                       |                                            | Washingt                               |                                                  |
|          | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               | 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age                                                                                                   | (In yrs. last birth                      | Months Days                                              | Hours Min.                 | 8. Date of Birth<br>(Month, Day<br>Sept. 1 | v, Year) Co                            | thplace (State or Foreign<br>ountry)<br>cvland   |
|          | ש                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               | Usual Residence of Decedent                                                                                                                         | 10c. City, Town                          | or Location                                              |                            | Popular I                                  | .,1512                                 | 10d. Inside City Limits                          |
|          | Maryla<br>-f shov<br>fied at                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ţo                            | Maryland Washington                                                                                                                                 | Hagers                                   |                                                          |                            |                                            |                                        | 1 <b>X</b> Yes 2 No                              |
|          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 Is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.                                                                                                                                                                             | Funeral Directo               | 10e. Street and Number 1033 Main Avenue                                                                                                             |                                          | 10f. Zip Code                                            | 21740                      |                                            | 10g. Citizen of What Co                | ountry?                                          |
|          | ns 23a<br>must                                                                                                                                                                                                                                                                                                                                                                                                                                                               | eral                          | 11 Marital Status 12. Was Decedent E                                                                                                                | ver in U.S.                              | 13. Was Decedent of H                                    |                            | ecify Yes or No-                           |                                        |                                                  |
| 20       | s after of or itel                                                                                                                                                                                                                                                                                                                                                                                                                                                           | by Fur                        | Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ North Married  3 □ Widowed 4 □ Divorced  Armed Forces?  1 □ Yes 2 ☑ North Married Forces? |                                          | 1 ☐ Yes 2 ☒ No                                           |                            | Hican, etc.)                               |                                        | white                                            |
| 3-003p   | 2 hours<br>atural<br>cal Ex                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ted b                         | 15. Decedent's Education                                                                                                                            | 16a. D                                   | Decedent's Usual Occu                                    | pation                     |                                            | 16b. Kind of Business                  | /Industry                                        |
| 2        | vithin 7<br>ine.<br>han "n<br>e Medl                                                                                                                                                                                                                                                                                                                                                                                                                                         | Completed                     | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+                                                              | )                                        | Give kind of work done<br>life. DO NOT use retire<br>ner | aunng most of work<br>ed)  | ang                                        | restaura                               | n t                                              |
| 70       | filed v<br>Hygie<br>other t                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Be Co                         | 17. Father's Name (First, Middle, Last)                                                                                                             | j Ow.                                    | net.                                                     | 18. Mother's Nam           | e (First, Middle,                          | Maiden Surname)                        | II C                                             |
| Jand     | Mental<br>Mental<br>arked c                                                                                                                                                                                                                                                                                                                                                                                                                                                  | To B                          | Elmer McAfee                                                                                                                                        |                                          |                                                          | Ev                         | zelyn                                      | Miller                                 |                                                  |
| Mar      | d 2 sho<br>th and<br>t7 Is m<br>traum                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               | 19a. Informant's Name/Relationship (Type. Print)  MacEtta McAfee                                                                                    |                                          | Mailing Address <i>(Street</i><br>33 Main Ave            |                            |                                            | er, City or Town, State,<br>Maryland ( | Zip Code)<br>21740                               |
| e,       | ss 1 an<br>of Heal<br>item 2                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               | 20a. Method of Disposition                                                                                                                          |                                          | Disposition (Name of crematory or other pla              | 1                          | Date                                       | 20c. Location - City or                |                                                  |
| Daltimor | : Page<br>tment<br>tant: If<br>jury or                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)                                                                    |                                          | ill Cemeter                                              | ry Febr                    | uary<br>2008                               |                                        | n, Maryland                                      |
| מ        | permit<br>Depar<br>Impor<br>any In<br>once,                                                                                                                                                                                                                                                                                                                                                                                                                                  |                               | 21. Signature of Tuneral Service Licenson                                                                                                           | mus                                      | 22. Name and Address 5 East V                            |                            |                                            | Funeral Horerstown, M.                 | me<br>aryland 21740                              |
|          | A R                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               | 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line                               | the death. Do no                         |                                                          |                            |                                            |                                        | Approximate<br>Interval Between                  |
|          | Physician<br>/Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               | Immediate Cause (Final disease or condition resulting in death)                                                                                     |                                          | unia                                                     |                            |                                            |                                        | Onset and Death                                  |
|          | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               | Due to (or as a                                                                                                                                     | consequence of                           | n):<br>—                                                 |                            |                                            |                                        |                                                  |
| ٩        | ed sit                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | iner                          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                         | consequence of                           | f):                                                      |                            |                                            |                                        |                                                  |
| 'n       | e executed<br>ian and<br>urial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                       | Examiner                      | that initiated events c.                                                                                                                            | consequence of                           | r):                                                      |                            |                                            |                                        |                                                  |
| 09/90    | cate be<br>physicia<br>the bur                                                                                                                                                                                                                                                                                                                                                                                                                                               | dical                         | d                                                                                                                                                   |                                          |                                                          |                            |                                            |                                        |                                                  |
| o XOO    | n certific                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | n/Me                          | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome p                                                                                        |                                          | -0=                                                      |                            |                                            | 23d. Date of de                        | livery                                           |
|          | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit                                                                                                                                                                                                                                                                                                                         | Completed by Physician/Medica | in the past 12 months?  1  Yes 2 No 9 Unknown                                                                                                       |                                          | 3 ☐ Ectopic pregnand<br>5 ☐ Other (specify) _            | :у<br>                     |                                            | Month                                  | Day Year                                         |
| Ţ.       | that the<br>ned by the<br>detach                                                                                                                                                                                                                                                                                                                                                                                                                                             | y Phy                         | Part II. Other significant conditions contributing to death but                                                                                     | t not resulting in t                     | the underlying cause gi                                  | ven in Part I.             | 23e. Did to                                | obacco use contribute t                | o the cause of death?                            |
| ecords,  | equires<br>en sigi<br>ould be                                                                                                                                                                                                                                                                                                                                                                                                                                                | ed b                          | COPB, CAD                                                                                                                                           | /                                        |                                                          |                            | 1 🗆 Y                                      | res 2 No 3 □ P                         | robably 4 Unknown                                |
| ž<br>L   | ne law r<br>has be<br>ge 2 sh                                                                                                                                                                                                                                                                                                                                                                                                                                                | mple                          |                                                                                                                                                     |                                          |                                                          |                            | 24a. Was autop                             | rmed? prior to                         | utopsy findings available completion of cause of |
| N I G    | an: Th<br>rtificate<br>tor, pa                                                                                                                                                                                                                                                                                                                                                                                                                                               | Be Co                         | 25. Was case referred to medical                                                                                                                    |                                          |                                                          | 26. Place of Dea           | 1 Yes                                      | 2D No 1 1 Yes                          |                                                  |
| > 10     | hysici<br>his ce<br>Il direc                                                                                                                                                                                                                                                                                                                                                                                                                                                 | To B                          | examiner? 1   Yes   2   No   Hospital: 1   Inpatier                                                                                                 |                                          | Datiett 3 DOA                                            | her:<br>4  Nursing H       | ome Resid                                  | dence 6 □Other (Spe                    | ecify)                                           |
| Sion     | ding P<br>h.<br>After t<br>funera                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               | 27. Manner of Death  1 Natural 5 Pending (Month, Day)  2 Accident investigation                                                                     | Year) 28b. Tii<br>Year) Inj              | jury Wo                                                  | uryat<br>ork?<br>]Yes 2∐No | 28d. Describe h                            | now injury occurred                    |                                                  |
| <u> </u> | r Attending<br>er death.<br>irector: After                                                                                                                                                                                                                                                                                                                                                                                                                                   | Certification:                | e Could not be                                                                                                                                      | ry - At home, farr<br>( <i>Specify</i> ) | m, street, factory, office                               |                            | 28f. Location (S<br>City or Tow            | Street and Number or F<br>vn, State)   | Route Number,                                    |
| ם        | spital o                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               | 29a. Certiffer 1 CertifyIng Physician: To the best o                                                                                                | f my knowledge.                          | death occurred at the t                                  | time, date and place       | and due to the                             | cause(s) and manner a                  | s stated.                                        |
|          | To the Hospital or Attending Physician: The law requires that the death certificate by within 24 thours after death certificate by within 24 thours after death. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the completely filled in by the funeral director, page 2 should be detached for use as the but the completely filled in by the funeral director. | Medical                       | (Check only one)  2 Medical Examiner: On the basis of and manner state                                                                              | examination and                          |                                                          |                            |                                            |                                        |                                                  |
|          | With Com                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Σ                             | 29b. Signature and fittle of certifier                                                                                                              |                                          | 2                                                        | se number                  |                                            | 29d. Date signed ( <i>Mon</i>          |                                                  |
|          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               | 30. Name and address of person who completed cause of de                                                                                            | ath (Item 23a) (T                        | Type, Print) DR                                          | . Khalid 1                 | nah move                                   | 1                                      | / 0                                              |
| 5        | H-8                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               | 580 NORTHERN AUE HAGE 31. Date filed (Month, Day, Year) 32. Registra                                                                                | RS TOW                                   |                                                          | 21742                      |                                            | `                                      |                                                  |
|          | Sta<br>Registr                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                               | FEB 1 4 2008                                                                                                                                        | S Gigitature                             | Boards .                                                 |                            |                                            |                                        |                                                  |
| DUIL     | AH 17 Pay 1/2                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 204                           |                                                                                                                                                     | - 15                                     | 3                                                        |                            |                                            |                                        |                                                  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Theodore Mason 2008 6:24 Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 22, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days 15 M 2 F Hours 49 Director Germany 579-74-3818 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show at r 28a-f sh notifled 1 Yes 2 No Director Prince Georges Bowie 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 627 Evening Star Pl. 20721 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify þ 3 ☐ Widowed 4 ☑ Divorced Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygiens Important: If Item 27 is marked other that any Injury or other traumatic event than Consultant Digitest 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ William Mason Yvonne Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Mason-Former Wife 627 Evening Star Pl. Bowie, Md. 20721 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Haven 2-15-2008 Silver Spring, MD. 21. Signature of Fundal Service Licensee 22. Name and Address of Facility
Murray Funeral Home leshound 4804 Georgia Ave. · Ukill NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** evobvo d+67 25 U /Medical Due to (or as a consequence of): Examiner AVTEN 51 UT if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed physician and s the burial-trans Due to (or as a consequence of) ್ರಿ ಎರ್ನ್ಸ್ M ೮ Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 | Dinknown been signated Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy death? 1 ☐ Yes 2 A No Division or Vital 1∐ Yes 2☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **N**O P 1 Anpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural Injury 5 Pending investigation death. 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fo the within 24 hours the Funeral D' 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CR-(5)

State Registrar 31. Date filed (Month, Day, Year)
FEB 1 2 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Feb-10-2008

Ave- SE- DC 20037

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month Delbert Lawson Markley, Sr. February 2008 3:00 P 12, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 701 Hilltop Drive Cumberland Allegany if Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 M 2□ F 74 214-32-3350 West Virginia 11/7/1933 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No MD Allegany Cumberland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21502 701 Hilltop Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No 1952 — If Yes, Give Year or Dates: 1977 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced 1977 White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Respiratory Therapist Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Markley Emma Frances 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janetta R. Markley / Wife 701 Hilltop Drive, Cumberland, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cem @ Rocky Gap 2/15/2008 Flintstone, MD Vet. 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Licens 404 Decatur Street, Cumberland, MD 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 25 resulting in death) (or as a consequence of) Sequentially list conditions, from the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

P

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and air by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital o within 24 hours af To the Funeral D

Division or Vital Records, P.O. Box 68760,

Examiner Completed by Physician/Medical Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? I□Yes 2□No 9 Unknown

24a. Was an autopsy performe

2 1 No

1∐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 1 No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 28a. Date of Injury 28b. Time of (Month, Day Year) Injury

Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only one)

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

26. Place of Death (Check only one)

29b. Signature and title of pertifier

D0054004

February 13, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shiv C. Khanna, M.D., 1221 National Highway, LaVale, Maryland

31. Date filed (Month, Day, Year) FEB 1 4 2008 State Registrar

Medical

32. gistrar's Signature

nas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Louella Martin 10, February 2008 1405 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 🗓 F 217-28-0011 12/23/1930 Maryland Usual Residence of Decedent 10d. Inside City Limits

1 ☐ Yes 2 No

White

Crabtree

Approximate Interval Between Onset and Death

4 DAYS

Day

2 No

2008

29d. Date signed (Month, Day, Year)

February

Year

4 VUnknown

**Funeral** Director

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

2

Certification:

Medical

State

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

VIK POONAI, MD

31. Date filed (Month, Day, Year)

FEB 1 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the Maryland r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

72 hours after 12 should be filed w h and Mental Hygier Is marked other th permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is r any Injury or other traur

Baltimore, Maryland 21215-0036

**Physician** /Medicai **Examiner** 

burial-transit attending physician as the nse be detached for the signed by After this certificate has page 2 director, funeral To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral

death certificate be executed

P.O. Box 68760,

Division or Vital Records,

The

Physician:

10a. State 10c. Cify, Town or Location 10h. County Cumberland MD Allegany 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21502 USA 14225 Hazen Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Yes 2 ☑ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Bookkeeper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Perdew Dora Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 818 Maplewood Lane, Cumberland, MD Leonard E. Martin / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 ☐Removal from State MD Vet Cem @ Rocky Gap 2/13/2008 4 Donation 5 Other (Specify) Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Sigha are of Funeral Service License 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition disease or condition resulting in death) SEVERE ANEMIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? THROMBOCYTOPENIA 1 TYes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 npatient 2 ER/Outpatient 3 DOA 27. Mary er of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

DHMH 17 Rev 1/2001

5

nes

924 SETON DRIVE, CUMBERLAND, MD

Registrar's Signature

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D36766

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Time of Death **Physician** Franklin William Matthews February 2008 5:30 10. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days 83 Director 218-16-3769 09/11/1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Allegany Corriganville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 10808 Kreigbaum Road (P.O. Box 34) 21524 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or iter 1 N Yes 2 No 1943-1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 ☑ No Specify Specify: 3 Widowed 4 Divorced White Year or Dates: 1945 Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Safety Inspector Ballistics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Ellen Llewellyn Matthews Elizabeth Strube 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10808 Kreigbaum Rd, P.O. Box 34, Corriganville, MD Lois V. Matthews/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stat permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Mem. Gardens 2/13/2008 LaVale, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Lice 404 Decatur Street, Cumberland, MD 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Coronary artery disease wears /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and Due to (or as a consequence of): physician a Box 68760. Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. signed by the a □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Colon carcinoma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 page certificate 1 🗆 Yes rector, 25. Was case referred to medical To Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 □ Yes 1 🕅 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 M Natural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: Hospital or Attending 5 Pending investigation Injury (Month, Day Year) thin 24 hours after death.

the Funeral Director: A suppletely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 2008 D54004 February 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nos Shiv Khanna, M.D., 1221 National Highway, LaVale, Maryland

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

FEB 1 1 2008

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JACK KENNEDY MURPHY, JR. 02 09 2008 2215 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS - BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F 214-42-0348 65 Director 01/19/1943 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at MD Allegany Cumberland 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be nooce. 35 Browning Street USA 21502 Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1∭Yes 2□No 1961**–** If Yes, Give Year or Dates: 1963 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 Divorced White 1963 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kennedy Murphy, Sr. Dorothy Isabelle Pownall Jack ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Browning Street, Cumberland, MD Bonita C. Murphy / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Vet Cem @ Rocky Gap 2/14/2008 4 ☐ Donation 5 ☐ Other (Specify) Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Licen 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SMALL METASTAD CELL ILLING years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Examine or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 3-☑ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performe To the Hospital Comments within 24 hours after death. To the Funeral Director: After this certificate I commendetely filled in by the funeral director, pag 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 3□ DOA ဥ 2 ER/Outpatient 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

2008

29c. License number

umberland

29d. Date signed (Month, Day, Year)

(Item 23a) (Type, Print)

Seton Registrar's Signature

Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Shop WHISH ROACL, Cumberland, MIL

Year 80

Black, White, etc.

White

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Approximate Interval Between Onset and Death

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Day

3 ☐ Probably 4 ☐ Unknown

Month

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Year

0800

Birthplace (State or Foreign Country)

10d. Inside City Limits

1X Yes 2 □ No

Maryland

State Registrar

2

Medical

(Check only one)

29b. Signature and title of gertifier

31. Date filed (Month, Day, Year) FEB 1 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

1 🔀 certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

6

ms

EREDERICK

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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CHURCHHILL 2D

|              |                                                                                                                                                                     |                   | 1 - State State Registrar                                                                                                                         | *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Department of Ho<br>Certificate of D                                                               |                                       | lental Hygier<br>Reg. I                 |                                                    |                                                    |
|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------|----------------------------------------------------|----------------------------------------------------|
| ľ            | Physici<br>/Medi                                                                                                                                                    |                   | 1. Decedent's Name (First, Middle, Last)                                                                                                          | Joseph Nell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                    |                                       | 2. Date of Death                        | Day Year                                           | 3. Time of Death A                                 |
| )            | Examir                                                                                                                                                              |                   | 4a. Facility Name (If not institution, give street and r.  Morningside House  5. Social Security Number 6. Sex                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4b. City, Town, or Ellicot                                                                         |                                       |                                         | 4c. County of Death<br>Howard                      | place (State or Foreign                            |
|              | Director                                                                                                                                                            |                   | 089-03-5341                                                                                                                                       | 89                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Yrs.                                                                                               | Tiours IVIII.                         | Sept 24,1                               | 1918   New                                         | York                                               |
|              | Marylar<br>a-f show                                                                                                                                                 | ctor              | 10a. State 10b. County  MD Howard                                                                                                                 | 10c. City, Towr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ott City                                                                                           |                                       |                                         |                                                    | 10d. Inside City Limits 1 ☐ Yes 2 X No             |
|              | th with the<br>23a or 28<br>ist be not                                                                                                                              | al Director       | 10e. Street and Number<br>5330 Dorsey Hall Drive                                                                                                  | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 10f. Zip Code                                                                                      | 042                                   |                                         | Citizen of What Coun                               | •                                                  |
| 036          | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or tlems 23a or 28a-f show<br>int, the Medical Examiner must be notifled at | by Funeral        | 1 Never Married 3 Married 17 Yes                                                                                                                  | ccedent Ever in U.S.<br>Forces?<br>s 2  No<br>Give<br>Dates: <b>WWII</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 13. Was Decedent of His If Yes, specify Cubar                                                      | spanic Origin? (Spen, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)        | 14. Race - Americ<br>Black, White,<br>Specify Whit | etc.                                               |
| 1215-0036    | d within 72 ho<br>giene.<br>r than "natu<br>the Medical                                                                                                             | Completed         | 15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12)  College 5+                                            | (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Decedent's Usual Occupa<br>(Give kind of work done di<br>life. DO NOT use retired)<br>easurer/Chie | uring most of worki                   | ing                                     | Kind of Business/In                                | dustry                                             |
| Maryland 21  | be de eve                                                                                                                                                           | To Be Co          | 17. Father's Name (First, Middle, Last)  Joseph Nell                                                                                              | 111                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                    |                                       | (First, Middle, Maid                    |                                                    |                                                    |
|              | nd 2 shatth and 27 is m                                                                                                                                             |                   | 19a. Informant's Name/Relationship (Type. Print)<br>Katherine McCullough/St                                                                       | epdaught, 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Mailing Address (Street a 702 Bounty Co                                                            | ourt Elli                             | icott City                              | , MD 2104                                          | .3                                                 |
| altimore,    | Page<br>nent o<br>ant: If<br>ury or                                                                                                                                 |                   | 20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee | m State cemeter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | f Disposition (Name of<br>ry, crematory or other place<br>t Crematory<br>22. Name and Addres:      | 2-11-                                 | -2008 Ha                                | Location - City or To<br>anover, MD<br>ke's Fami   |                                                    |
| Ä            | permit. Departr Imports any inji                                                                                                                                    |                   | 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or                                              | t caused the death. Do r                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4112 01d C                                                                                         | olumbia I                             | Pike Ellic                              |                                                    |                                                    |
| 68760,       | Physician /Medical Examiner  the pnial-transit                                                                                                                      | al Examiner       | Sequentially list conditions, if any, leading to thin educate cause. Enter Underlying Cause (Disease or Injury that initiated events c.           | o (or as a consequence of the co | on:<br>NER'S DISEA                                                                                 | +se                                   |                                         |                                                    | Onset and Death                                    |
| .O. Box (    | The law requires that the death certificate tee has been signed by the attending physique 2 should be detached for use as the                                       | Physician/Medical | in the past 12 months?                                                                                                                            | outcome pf pregnancy<br>e birth 2 □ Fetal death<br>gnant at time of death<br>known                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 3 □Ectopic pregnancy<br>5 □ Other (specify)                                                        |                                       |                                         | 23d. Date of deliv                                 | ery<br>Day Year                                    |
| Records, P   | w requires that<br>been signed b<br>should be deta                                                                                                                  | by                | Part II. Other significant conditions contributing to                                                                                             | death but not resulting ir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | n the underlying cause give                                                                        | n in Part I.                          | 23e. Did tobacc                         | co use contribute to t                             | he cause of death?                                 |
| tai Rec      |                                                                                                                                                                     | e Completed       | 25. Was case referred to medical                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    | OC Place of Booth                     | 24a. Was an autopsy performed 1 Yes 2 X | prior to co<br>l? death?                           | opsy findings available impletion of cause of 2 No |
| ion or Vital | ing Phys<br>After this<br>uneral dir                                                                                                                                | To B              | examiner? 1 Yes 2 No Hospital: 1   27. Manner of Death 28a. Da                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Time of 28c. Injury                                                                                | r:<br>4□ Nursing Ho                   |                                         |                                                    | <sub>fy</sub> asst. livo                           |
| Division     | i Dir                                                                                                                                                               | Certification:    | 4 Homicide distributed bui                                                                                                                        | lding, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | erm, street, factory, office                                                                       |                                       | City or Town, Si                        | ·                                                  |                                                    |
|              | To the Hospital within 24 hours a Youngetely filled                                                                                                                 | Medical           | 29a. Certifier (Check only one)  1                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    | pinion, death occur                   | red at the time, date                   | and place, and due                                 | lo the cause(s)                                    |
| 6            | 10) as                                                                                                                                                              |                   | 30. Name and address of person the completed ca                                                                                                   | use of death (Item 23a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | DSV                                                                                                | 404                                   |                                         | JANTEB                                             | 11,08                                              |
| لا)          | Sta                                                                                                                                                                 | ate               | 8601 VETERANS HWY 31. Date filed (Month, Day, Year) 32                                                                                            | SWITE       Registrar's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | MILLERS                                                                                            | MUE, M                                | D 211                                   | 108                                                |                                                    |
|              | Regist                                                                                                                                                              | rar               | FEB 1 2 2008                                                                                                                                      | Elecus A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Spelle                                                                                             |                                       |                                         |                                                    |                                                    |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** Keith Kenneth Nauman February 07 2008 1849 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. . Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F North Dakota Director 501-92-2922 May 03, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show a notified at 1 ☐ Yes 2K No Director Montgomery Clarksburg Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 23211 Bent Arrow Drive 20871 U.S.A. Funeral iral", or items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 27 Is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Kenneth Nauman Diane Dassinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I Myong Nauman - Spouse 23211 Bent Arrow Drive, Clarksburg, Maryland 20871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 02/15/2008 Brentwood, Maryland 22. Name and Address of Facility Signature of Funeral Ferrice Livenses Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a Part1. Enter the disease, or com shock, or heart failure. List only complications that caused the death, only one cause on each line. not enter the mode of dying, such as, cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of) Examine the burial-transit Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 100 certificate ha Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 R/Outpatient Medical Certification: To 1 ☐ Inpatient 3☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 nours after death.

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y filled in by the fu within 24 hours at To the Funeral C completely filled i

To the

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) FEB 1 2

(Check only

29b. Signature and title of certifier

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Ty

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Peggy Joyce New Feb. 2008 6:04 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13153 Little Hayden Circle Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | 03/27/1937 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 70 095-30-7770 Director NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Citrus FLHomosassa 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Pitcairn Court 34446 US Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 9 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 Is marked other than ' Irry or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Robert William Bassford Leona Bertha Vancour ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. New / Husband 13153 Little Hayden Circle, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 XICremation 3 ☐ Removal from State Smithsburg Crematory | 02/13/2008 | Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Physician disease or condition resulting in death) 6 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or se a consequence of) Examine certificate be executed use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the at d be detached fo 4☐Pregnant at time of death 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy performed? res 2 No 1□ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Latural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) God Brund 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blva Smithibury MD 21783 1H-12 22911 BROWN,

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

|                     |                                                                                                                                                                                                                                                                                                                                               |                     | 1 - For<br>Stata<br>Registrar                                                                                                               |                                                        | f Maryland / D                                               | epartment o<br>Certificate                                                   |                                          |                                                      | iene<br>g. No.2008                              | 06028                                              |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------|-------------------------------------------------|----------------------------------------------------|
|                     | Physici<br>/Medic                                                                                                                                                                                                                                                                                                                             |                     | 1. Decedent's Name (First, Middle Edit Quidre C. O                                                                                          | N                                                      |                                                              |                                                                              |                                          | 2. Date of Deal<br>Month                             | Day Year                                        | 3. Time of Death                                   |
| is .                | Examir                                                                                                                                                                                                                                                                                                                                        | er                  | 4a. Facility Name (If not institution 100 Monument S                                                                                        | quare                                                  |                                                              |                                                                              | wn, or Location of E<br>Salisbur         | У                                                    |                                                 | mico                                               |
|                     | Funeral<br>Director                                                                                                                                                                                                                                                                                                                           |                     | 5. Social Security Number 215.22.0985 Usuel Residence of Decedent                                                                           | 6. Sex<br>1 ☐ M 2 ☐ F                                  | 7. Age (In yrs. last birth                                   |                                                                              |                                          | Min. 8. Date of Birth (Month, Day)  Jan • 30         |                                                 | plece (State or Foreign<br>intry)<br>7 York        |
|                     | within 72 hours after death with the Maryland<br>ane.<br>Than "naturel", or lieme 28a or 28a-f show<br>ha Medical Examiner must be notified at                                                                                                                                                                                                | ector               | 10a. State 10b. County Maryland Wicon 10e. Street and Number                                                                                | mico                                                   | 10c. City, Town                                              | or Location Salisbur                                                         | -3                                       | 1                                                    | 0g. Citizen of What Cou                         | 10d. Inside City Limits 1                          |
|                     | 23a or                                                                                                                                                                                                                                                                                                                                        | ai Dir              | 100 Monument Se                                                                                                                             | quare                                                  |                                                              | 101. 240 00                                                                  | 21804                                    |                                                      |                                                 | JSA                                                |
| 920                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mentel Hygians. Department of Health and Mentel Hygians.  The man of Health and Mentel Hygians.  The Medical Examiner must be notified at any highry or other treumstic event, the Medical Examiner must be notified at any page. | by Funeral Director | 11. Marital Slatus 1 □ Never Married 2 □ Marr 3 ☑ Widowed 4 □ Divorced                                                                      | Armed Fo                                               | 2 <b>2</b> √No<br>θ                                          | 13. Was Deceden If Yes, specify 1 Yes 2                                      | /                                        | n? (Specify Yes or No-<br>Puerto Rican, etc.)        | 14. Race - Amer<br>Black, White<br>Specify:     |                                                    |
| 21215-0036          | within 72 ho<br>ane.<br>than "natu                                                                                                                                                                                                                                                                                                            | Completed           | 15. Deceden<br>(Specify only highes<br>Elementary/Secondary (0-12)<br>12                                                                    | 's Education<br>it grade completed)<br>College (1      |                                                              | Decedent's Usual C<br>Give kind of work of<br>life. DO NOT use i<br>Homemake | done during most o<br>retired)           | f working                                            | 16b. Kind of Business/li                        | ndustry                                            |
| /land 2             | uld be filed<br>Mentel Hygi<br>irked other<br>itic event, I                                                                                                                                                                                                                                                                                   | To Be Co            | 17. Father's Name (First, Middle,<br>Henry Seagrave                                                                                         |                                                        | con                                                          | nomemare                                                                     | 18. Mother's                             | Name (First, Middle, I                               | Own H<br>Maiden Sumame)                         | lome                                               |
| Mar                 | nd 2 sho<br>lith and !<br>27 ie ma<br>r treuma                                                                                                                                                                                                                                                                                                |                     | 19a. Informant's Name/Relations! Audrey E. Orr/I                                                                                            |                                                        |                                                              |                                                                              | treet and Number o                       | or Rural Route Number                                | City or Town, State, Zi                         |                                                    |
| Baltimore, Maryland | Pages 1 al                                                                                                                                                                                                                                                                                                                                    |                     | 20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (S)                                                                    | 3 ☐Removal from 5                                      | 20b. Place of E<br>cemetery,                                 | Disposition (Name<br>crematory or othe                                       | of<br>or place)                          | Date                                                 | 20c. Location - City or T<br>8 Church Cr        | own, Slate                                         |
| Balti               | permit. Depertm Importe eny inju                                                                                                                                                                                                                                                                                                              |                     | 21, Signature of Funeral Service                                                                                                            | ea- Juli                                               | nuveel                                                       | 22. Name and A<br>Curran-<br>308 His                                         | Address of Facility Bromwell h St        | Funeral Ho<br>ambridge                               | ome, P.A.                                       | ,                                                  |
|                     | Physician<br>/Medical                                                                                                                                                                                                                                                                                                                         |                     | 23a. Part1. Enter the disease, or<br>shock, or heart failure. List<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | aa                                                     | CVA                                                          | t enter the mode o                                                           | of dying, such as ca                     | rdiac or respiratory arm                             | est,                                            | Approximate<br>Interval Between<br>Onset and Death |
|                     | Examiner                                                                                                                                                                                                                                                                                                                                      | iner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                 | b                                                      | or as a consequence of A A X X X X X X X X X X X X X X X X X | Esalla                                                                       | **                                       |                                                      |                                                 |                                                    |
| 8760, <             | cate be executed physicien and the burial-transit                                                                                                                                                                                                                                                                                             | Ical Examiner       | that initiated events<br>resulting in death) Last                                                                                           | cDue to (                                              | or as a consequence of                                       | ):<br>                                                                       |                                          |                                                      |                                                 |                                                    |
| P.O. Box 68         | The law requires that the death certificate be executed its has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit                                                                                                                                                                            | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown                                                     | 1 ☐ Live bi                                            | come of pregnancy rth 2 Petal death ant at time of death wn  | 3 ☐Ectopic pregr                                                             |                                          |                                                      | 23d. Date of delive Month                       | rery<br>Day Year                                   |
| rds, P              | w requires that<br>been signed b<br>should be deta                                                                                                                                                                                                                                                                                            | ρ                   | Part II. Other significant condition                                                                                                        | ns contributing to de                                  | ath but not resulting in t                                   | he underlying caus                                                           | se given in Part I.                      |                                                      | pacco use contribute to                         |                                                    |
|                     | : The law re<br>cate has be<br>; page 2 sho                                                                                                                                                                                                                                                                                                   | Completed           |                                                                                                                                             |                                                        |                                                              |                                                                              |                                          | 24a. Was a autops perforr                            | v prior to c                                    | opsy findings available ompletion of cause of 2 No |
| r Sit               | ysician<br>is certifi<br>director                                                                                                                                                                                                                                                                                                             | To Be               | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No                                                                                  | Hospital: 1 □ II                                       | npatient 2 ER/Outp                                           | atient 3 DOA                                                                 | Othon                                    | Death Check only on                                  | e)<br>ance 6 □Other (Spec                       | (v)                                                |
| sion o              | To the Hospital or Attending Physician: The i within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page                                                                                                                                                              | Certification; 7    | 27. Manner of Death  1                                                                                                                      | ation                                                  | f Injury 28b. Tir                                            |                                                                              | Injury al Work?                          | 28d. Describe ho                                     | w injury occurred                               |                                                    |
| <u>×</u>            | ital or Att<br>irs after d<br>rei Direct<br>led in by                                                                                                                                                                                                                                                                                         |                     | 3 ☐ Suicide 6 ☐ Could r<br>4 ☐ Homicide determi                                                                                             | ned 286. Place                                         | of Injury - AI home, farn<br>ng, etc. (Specify)              | n, street, factory, or                                                       | ffice                                    | 28f. Location (St<br>City or Town                    | reet and Number or Rui<br>n, State)             | al Route Number,                                   |
|                     | To the Hospital within 24 hours a To the Funerel I completely filled                                                                                                                                                                                                                                                                          | Medical             | 29a. Certifier 1 Certifyin (Check only one)                                                                                                 | g Physician: To the<br>Exeminar: On the ba<br>and mann | sis of examination and/                                      | death occurred at to<br>or investigation, in                                 | he time, date and p<br>my opinion, death | place, and due to the ca<br>occurred at the time, do | ause(s) and manner as<br>ate and place, and due | stated.<br>to the cause(s)                         |
| )                   | Vith<br>CO<br>TO<br>TO                                                                                                                                                                                                                                                                                                                        | 2                   | 29b. Signature and title of certifier                                                                                                       |                                                        |                                                              |                                                                              | icense number                            |                                                      | 9d. Date signed (Month)                         |                                                    |
|                     | Ģ                                                                                                                                                                                                                                                                                                                                             |                     | 30. Name and address of person                                                                                                              | who completed cause                                    |                                                              |                                                                              | ~>                                       | Salub                                                | 2/18/200<br>M 2/20)                             | /                                                  |
|                     | Sta<br>Registr                                                                                                                                                                                                                                                                                                                                |                     | 31. Date filed (Month, Day, Year) FEB 2 7                                                                                                   | 490                                                    | gistrar's Signature                                          | Angel a                                                                      |                                          | 3.810-)                                              |                                                 | -                                                  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last)
Kaaren Oakley 2. Date of Death **Physician** Febn 23 2008 ay 9 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 431 Lessin Drive Lusby Calvert Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 218-38-5029 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months Hours Jahran 9 31 - 1942 1 M 2 F New York Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at Calvert 1 ☐ Yes 2 No Maryland Director Lusby 10f. Zip Code 20657 10g. Citizen of What Country?
United States 10e. Street and Number 431 Lessin Drive Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married white Baltimore, Maryland 21215-0036 1□ Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) hammaker own Home permit. Pages 1 and 2 should be filed v Department of Health and Mentai Hygit Important: If item 27 is marked other i any Injury or other traumatic event, <u>it</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Karl Karlstrom Mary Shields 19a Informant's Name/Relationship (Type. Print) Walter F. Oakley — husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 431 Lessin Drive Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State Feb 25 20008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Raysch Funeral Home 20 American Lane Lusby MD 20057 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC PULMONARY **Physician** OBSTRUCTIVE resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DISEASE ROHN 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5€ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 ☐ Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tt Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 040370 121) 08 30 Name and address of person was completed cause of death of tem \$32 Hz p3 10 nt Prince Frederick MD 20678 Peter Wishiewski, MD 1970 to the spital to the Statter of the Prince Frederick MD 20678 0 31. Date filed (Month, Day, Year) FEB 27 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

Mars.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death v 6 2008 **Physician** Outler Lula Ann 10:40 AM February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbury Wicomico Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 3/2/1912 Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours Maryland 95 Yrs 136-28-4004 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 TYYes 2 □ No Director Wicomico Salisbury Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 USA 900 Booth St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Specify. white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) domestic housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Turner George A. Hurtt ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 82 Jacobs Creek Rd., W. Trenton, NJ 08628 Beverly J. Topley/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐Removal from State 2/8/08 4 □ Donation 5 □ Other (Specify) Salisbury Crematory Salisbury, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP Oracamoral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVD **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transi Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy has been signed by the atte ye 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an 1□ Yes E No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

29a. Certifier

(Check only one)

30. Name and address o

29b. Signature and tipe of certifier

person who completed cause of death (Item 23a) (Type, Print) Salisbury MD 21804 614 Easternshore Dr Yogesh Wohra 31. Date filed (Month, Day, Year) FEB 12 egistrar's Signature 2008

State Registrar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

08-01513 Nev

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| vin R. Petre                                                                                                                                                                                                                                                                     |                | - For State                                                       | ate of Marylar                            | nd / Departm<br><i>Certific</i>        | ent of ate of         | Health a<br><i>Death</i>        | nd Menta                        | al Hygie                     | ne<br>Reg.                                   | No. 20                                          | 08 0603                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------|-------------------------------------------|----------------------------------------|-----------------------|---------------------------------|---------------------------------|------------------------------|----------------------------------------------|-------------------------------------------------|---------------------------------------------------------------|
| Physicia                                                                                                                                                                                                                                                                         | ın/            | Registrar  1. Decedent's Name (First, Middle                      |                                           |                                        |                       |                                 |                                 |                              | te of Death<br>onth D<br>bruary 21,          | ay Year                                         | 3. Time of Death<br>1423 hrs                                  |
| edical Exami                                                                                                                                                                                                                                                                     |                | Nevin  4a. Facility Name (if not institution                      | Ray Petre                                 |                                        | 4                     | b. City, Town,                  | or Location of                  |                              | bruary 21,                                   | 4c. County of Dea                               | ath                                                           |
|                                                                                                                                                                                                                                                                                  |                | Washington County H                                               |                                           | ,                                      |                       | Hagersto                        |                                 |                              |                                              | Washington                                      |                                                               |
| Funeral<br>Director                                                                                                                                                                                                                                                              |                | 5. Social Security Number 213-27-2197                             | 6. Sex                                    | 7. Age (In yrs. last bit               | rthday)<br>Yrs.       |                                 | ear If Under<br>ays Hours       | <del></del>                  | Date of Birth ( $0v.9,1$                     | For                                             | Birthplace (State or<br>reign <b>Pennsylvania</b><br>Country) |
|                                                                                                                                                                                                                                                                                  | Ł              | Usual Residence of Decedent                                       |                                           |                                        |                       |                                 |                                 |                              |                                              |                                                 | 10d. Inside City Limits                                       |
| w any                                                                                                                                                                                                                                                                            |                | 10a. State 10b. County                                            | 7 4                                       | 10c. City, Town                        |                       |                                 |                                 |                              |                                              |                                                 | 1 Yes 2 X No                                                  |
| yland<br>-f sho                                                                                                                                                                                                                                                                  | ģ              | Md. Was                                                           | hington                                   |                                        | Boons                 | 10f, Zip Code                   | e                               |                              | 10g                                          | . Citizen of What C                             | ountry?                                                       |
| te Mar<br>or 28a                                                                                                                                                                                                                                                                 | Director       | 8306 Maplevill                                                    | e Rđ.                                     |                                        |                       | 217.                            | 13                              |                              |                                              | $U \cdot S$                                     | S.A                                                           |
| 21215-0036 Note that the Maryland hand be filed within 72 hours after death with the Maryland Mental Hygiene. Mental Hygiene. The Medical Examiner must be notified at once.                                                                                                     | Funeral [      | 11. Mantal Status  1 X Never Married 2 M                          | 12. Was Dece                              | edent Ever in U.S.                     | 13. Wa:               | s Decedent of<br>es, specify Cu | Hispanic Origi<br>ban, Mexican, | in? ( Specify<br>Puerto Rica | Yes or No-<br>n, etc.)                       | 14. Race - An<br>White, etc                     | nerican Indian, Black,<br>c.                                  |
| er deat<br>or ite                                                                                                                                                                                                                                                                | Fu             |                                                                   | 1 Yes                                     | 2XX No                                 | 1                     | Yes 2X                          | No specify:                     |                              |                                              | Specify: Wi                                     | h <b>ite</b>                                                  |
| urs afte<br>tural"                                                                                                                                                                                                                                                               | d b            | 15. Decedent's Education (Spe                                     | Lor Dates:                                |                                        | . Deceden             | t's Usual Occu                  | pation (Give k                  | kind of work (               | done 1                                       | 6b. Kind of Busine                              | ss/Industry                                                   |
| 5<br>72 hou<br>nn "na<br>cal Exi                                                                                                                                                                                                                                                 | Completed      | Elementary/Secondary (0-12)                                       | College (1                                | 4 or 5+)                               |                       | rarmer                          | ille. DO NOT                    | ase retired)                 |                                              | Farm                                            |                                                               |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica                                                                                                                                                                                           | ᇤ              | 17. Father's Name (First, Middle                                  | Last)                                     |                                        |                       | raimer                          | 18.Mother                       | 's Name (Firs                | st, Middle, Ma                               | aiden Surname)                                  |                                                               |
| e filed all Hyg                                                                                                                                                                                                                                                                  | Be C           | Samuel A. Pe                                                      |                                           |                                        |                       |                                 |                                 |                              | Petre                                        |                                                 |                                                               |
| MD 212<br>12 should b<br>th and Ment<br>27 is mark<br>umatic eve                                                                                                                                                                                                                 | TO E           | 19a. Informant's Name/Relations                                   | ship (Type, Print)                        |                                        |                       |                                 |                                 |                              |                                              | er, City or Town, S                             |                                                               |
|                                                                                                                                                                                                                                                                                  |                | Samuel A. Petre                                                   | (Father)                                  |                                        |                       | MapLev.                         |                                 |                              | nsborc<br>te                                 | o, Md . 217.<br>20c. Location - City            | y or Town, State                                              |
| altimore, MD 2: mit. Pages I and 2 shoulc spartment of Health and M portant: If item 27 is m jury or other traumatic e                                                                                                                                                           | 1 1            | 1 X Burial 2 Crematio                                             | n 3 Removal fr                            | om State Meado                         | natory or ot<br>W Vie | her place)<br>W Menn            | onite                           | $F \epsilon b$ .             |                                              | Hagerst                                         | cun Md                                                        |
| Baltimore permit. Pages I Department of I Important: If injury or other                                                                                                                                                                                                          |                | 4 Donation 5 Other S 21. Signature of Funeral Service             | pecify:                                   | Chur                                   | <i>ch Ce</i>          | <i>mcteru</i><br>Name and Ado   | ress of Facility                | 2008<br>y                    |                                              |                                                 | bury Ave.                                                     |
| Bal<br>perm<br>Depa<br>Impo                                                                                                                                                                                                                                                      | V 12           | T102-/-                                                           | 1 mis                                     | MO1414                                 |                       |                                 |                                 |                              | ome Sn                                       | ni thsburg                                      | ,Md.21783                                                     |
| Physician                                                                                                                                                                                                                                                                        |                | 23a. Part I. Enter the disease, of failure. List only one cause   | r complications that c<br>e on each line. | aused the death. Do                    | not enter t           | he mode of dy                   | ring, such as c                 | cardiac or res               | piratory arres                               | st, shock, or nean                              | Approximate Interval<br>Between Onset and<br>Death            |
| (amine                                                                                                                                                                                                                                                                           |                | Immediate Cause (Final diseas<br>or condition resulting in death) |                                           | uries<br>consequence of):              |                       |                                 |                                 |                              |                                              |                                                 | 5000                                                          |
|                                                                                                                                                                                                                                                                                  |                | Sequentially list conditions,                                     | b                                         | Consequence or).                       |                       |                                 |                                 |                              |                                              |                                                 |                                                               |
|                                                                                                                                                                                                                                                                                  | iner           | if any, leading to immediate cause. Enter Underlying Cause        |                                           | consequence of):                       |                       |                                 |                                 |                              |                                              |                                                 |                                                               |
| 1/ -                                                                                                                                                                                                                                                                             | Examiner       | (Disease or injury that initiated events resulting in death) Last | Due to for on a                           | consequence of):                       |                       |                                 |                                 |                              |                                              |                                                 |                                                               |
| executed an and and transit                                                                                                                                                                                                                                                      | 1 =            |                                                                   | d                                         |                                        |                       |                                 |                                 |                              |                                              |                                                 |                                                               |
| be be                                                                                                                                                                                                                                                                            | ledical        | UNPENDED  IF FEMALE:                                              | AMENDED 23c If yes                        | outcome of pregnan                     | ncv                   |                                 |                                 |                              |                                              | 23d. Date of de                                 | alivery                                                       |
| Box 6876; death certificate the attending phy                                                                                                                                                                                                                                    | Physician/M    | 23b. Was decedent pregnant in past 12 months?                     | the 1 Live                                | birth                                  | 2 F                   | etal death                      |                                 | ic pregnancy                 | ,                                            | Month                                           | Day Year                                                      |
| OX 6<br>eath ce<br>attend                                                                                                                                                                                                                                                        | sici           | 1 Yes 2 No 9 U                                                    | nknown g Unkr                             | nant at time of death<br>lown          | 5 C                   | ther (Specify)                  | )                               |                              |                                              |                                                 |                                                               |
| O. B<br>at the d                                                                                                                                                                                                                                                                 | F E            |                                                                   | itions contributing                       | o death but not resu                   | ilting in the         | underlying ca                   | use given in F                  | Part I.                      |                                              | bacco use contribu                              | te to the cause of death?                                     |
| r, P.O.                                                                                                                                                                                                                                                                          | þ              |                                                                   |                                           |                                        |                       |                                 |                                 |                              | 1 Yes                                        | 43 34 4 11                                      | ere autopsy findings available                                |
| ords<br>w requ                                                                                                                                                                                                                                                                   | Completed      |                                                                   |                                           |                                        |                       |                                 |                                 |                              | autop                                        | sy pric                                         | or to completion of cause of ath?                             |
| Reco                                                                                                                                                                                                                                                                             |                |                                                                   |                                           |                                        |                       |                                 |                                 |                              | 1 ✔ Yes                                      | 2 No 1                                          | Yes 2 No                                                      |
| tal F<br>cian:<br>certifi                                                                                                                                                                                                                                                        | Be C           |                                                                   | Hospital:                                 | Inpatient 2 🗸 El                       | R/Outnatie            |                                 | Place of Death<br>Other         | Nursing I                    |                                              | Residence 6                                     | Other:                                                        |
| of Vital Records, ng Physician: The law requir Mer this certificate has been 1                                                                                                                                                                                                   | <u> </u> 2     | 27 Manner of Death                                                | '                                         |                                        | 8b. Time of           |                                 | . Injury at Wo                  | rk?   28                     | d. Describe                                  | how injury occurred                             |                                                               |
| on C<br>ending<br>ath.                                                                                                                                                                                                                                                           | į              | 1 Natural 5 Pe                                                    | illuling                                  | e of Injury<br>th, Day Year)<br>, 2008 | 1308 hrs              | '                               | Yes 2                           | No                           |                                              | •                                               |                                                               |
| Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Pineral Director: After this certificate has been signed by the attending physician and the pineral Directors. | Certification: | 2 Accident Inv                                                    | ould not be                               | ice of Injury - At hom                 |                       | eet, factory, o                 | ffice building,                 | etc. 28                      | 3f. Location (3<br>or Town, S<br>i35 Mapleyi | Street and Number<br>State)<br>Ile Road, Hagers | or Rural Route Number, City                                   |
| Ospital<br>hours                                                                                                                                                                                                                                                                 | j j            |                                                                   | Di vista y Tathah                         | Sport/Athleti                          | death occ             | curred at the ti                | me, date and p                  | place, and du                | ue to the caus                               | se(s) and manner a                              | as stated.                                                    |
| the H<br>thin 24<br>the F                                                                                                                                                                                                                                                        | Medical        | (Check only one) 2 Medical E                                      | xaminer: On the basis<br>and manner       | of examination and                     | l/or investig         | ation, In my o                  | pinion, death                   | occurred at t                | he time, date                                | and place, and du                               | e to the cause(s)                                             |
| 5 Wild                                                                                                                                                                                                                                                                           | S S            | 29b. Signature and title of cert                                  |                                           | 1/2                                    |                       |                                 | icense numbe                    | er                           |                                              |                                                 | d (Month, Day, Year)                                          |
|                                                                                                                                                                                                                                                                                  |                | V.                                                                | W. Ce                                     |                                        |                       |                                 | D.C.M.E.                        |                              |                                              | February 22                                     | ., 2006                                                       |
| 2                                                                                                                                                                                                                                                                                |                | 30. Name and address of pers                                      | on who completed ca<br>eputy Chief Med    |                                        | 3a)<br>111 P          | enn Street                      | Baltimore                       | e, MD 212                    | 01                                           |                                                 |                                                               |
| 0                                                                                                                                                                                                                                                                                | Stat           |                                                                   | Tag                                       | Registrar's Signature                  |                       | 1 - 10 -                        |                                 |                              |                                              | <del></del>                                     |                                                               |
|                                                                                                                                                                                                                                                                                  | stat<br>istra  | a 31. Date filed (Month, Day Ye                                   | 7 2008                                    | Bolive A                               | r A                   |                                 |                                 |                              |                                              |                                                 |                                                               |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend #10c,17 & 20b per FH 02-13-2008 CNM
Registrar

Reg No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUAR Pay 6, 2008 E DEMAR 4:30P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Tawson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 M 2 M 20-34-5798 Director DAMASCUS Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits 28a-f show Examiner must be notified at New Market MO. FREDERICK 1 Nes 2 No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 6 21772 Items 23a A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced 'natural", I and z shouse the Hagene.
Health and Mental Hygiene.
Item 27 is marked other than "naturals event, the Medical." Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry NEPT OF ENERGY (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SERVISOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Neiper Lyles Be Simm ဂ္ 19a. Informant's Name/Relationship (Typg. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any Injury or other trau RAS NEW MARKET MA LIAM 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State NEW MARKET MA 4 □ Donation 5 □ Other (Specify) Comm. Com 22. Name and Address of Facility GARY L 21. Signature of Funeral Service idensee ROLLINS FLACERE None ST. FRED 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAYS Immediate Cause (Final disease or condition resulting in death) Physician ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner YEARS AORTIC STENOSIS SEVERE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed YEARS physician and s the burial-trans RECURRENT CONGESTIVE HEART FAILURE Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, END STAGE RENAL DISEASE-DIALYSIS DEPENDENT YEARS Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) by the a 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes DIABETES MELLITUS peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣No 24a. Was an has certificate ha autopsy 1 Yes 2 No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending investigation sefter de. eal Director: An 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours of To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

7601

30. Name and address of person who commeted cause of death (Item 23a) (Type, Print) M. D. ,

ILIA CEBALLOS

31. Date filed (Month, Day, Year)

OSLER DRIVE.

D25886

TOWSON.

MARYLAND 21204

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Oscar Padget February 5,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec 28, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F 215-36-2587 70 1937 Wash. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or iteme 23a or 28a-f show the Medical Examiner must be nutified at 1 Yes 2 No Prince George's Directo Bowie 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3850 Enfield Chase Court, #301 20716 USA Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 years Construction worker private other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: if Item 27 is marked oth any fulury or othar traumatic event 2008. Elliot Jackson Lottie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Valentine/daughter 64 Einstein Way, Martinsburg, WV 25404 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Brentwood, 20a. Method of Disposition MD Burial 2 Oremation 3 Removal from State Ft. Lincoln Feb 13,2008 4 □ Donation 5 ☑ Other (Specify) 21. Signature of Furreral Service Lie 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd, Landover, MD 20785 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death candiany opally **Physician** Ischemic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a deteched f □Yes 2□No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funeral Dire 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 036 29b. Signature and title of certifier mpleted cause of death (Item 23a) (Type, Print) D. Doroh Drive Claste, Md 21669 2118 NLL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 2 2008 Registrar

|                                            |                                                                                                                                                                                                                                                                                                  | -                                    | For State Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | of Maryland                                                                | •    | rtment of Hi<br>tificate of L                           |                                                                                 |                                                            | ene<br>g. No.                                                                                  |                                                    |                                                    |  |
|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------|---------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|--|
|                                            | Dhygiai                                                                                                                                                                                                                                                                                          |                                      | 1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Ves                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                | 0 0 8                                              | 3 Time of Death 5                                  |  |
| 4                                          | Physicia<br>/Medic                                                                                                                                                                                                                                                                               | al                                   | Oliver Parker Fe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |      |                                                         |                                                                                 | February                                                   | y 7                                                                                            | 2008                                               | 10:04a <sup>M</sup>                                |  |
| )                                          | Examin                                                                                                                                                                                                                                                                                           | er                                   | 4a. Facility Name (If not institution, give street and number)  Prince George's Community Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |      | 4b. City, Town, or Chever1:                             |                                                                                 | 4c. County of Death Prince George's                        |                                                                                                |                                                    |                                                    |  |
|                                            | Funeral<br>Director                                                                                                                                                                                                                                                                              | ,                                    | 5. Social Security Number 212–32–6731                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |      | Months Davs Hours Min.                                  |                                                                                 |                                                            | eate of Birth<br>Month, Day, Year)                                                             |                                                    | 9. Birthplace (State or Foreign Country)  Maryland |  |
| Baltimore, Maryland 21215-0036             | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 21's marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                                      | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    | Od. Inside City Limits                             |  |
|                                            |                                                                                                                                                                                                                                                                                                  | tor                                  | Maryland Prince George's Kettering ¹√x Yes 2□No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |
|                                            |                                                                                                                                                                                                                                                                                                  | Director                             | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |      | 10f. Zip Code                                           |                                                                                 | 10                                                         | 0g. Citizen                                                                                    | of What Coun                                       | try?                                               |  |
|                                            |                                                                                                                                                                                                                                                                                                  | ral                                  | 11411 Red Jade Court                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 1    | 20774                                                   |                                                                                 |                                                            | USA                                                                                            | Race - Americ                                      | an Indian                                          |  |
|                                            |                                                                                                                                                                                                                                                                                                  | Completed by Funeral                 | 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ecedent Ever in U.S.<br>Forces?<br>es 25 No<br>Give<br>r Dates:            |      | Vas Decedent of Hi<br>Yes, specify Cuba<br>☐ Yes 2 ☑ No | spanic Ongin? (Spen, Mexican, Puerto                                            | eciry Yes of No-<br>Rican, etc.)                           |                                                                                                | Black, White, ecity: Bla                           | etc.                                               |  |
|                                            |                                                                                                                                                                                                                                                                                                  |                                      | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |      |                                                         |                                                                                 | ing                                                        | 16b. Kind of Business/Industry                                                                 |                                                    |                                                    |  |
|                                            |                                                                                                                                                                                                                                                                                                  |                                      | Elementary/Secondary (0-12) Colleg                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | e (1-4or 5+)                                                               |      | k Mason                                                 | ,                                                                               |                                                            | George                                                                                         | e Hyman                                            | Cons. Co                                           |  |
|                                            |                                                                                                                                                                                                                                                                                                  | Be C                                 | 17. Father's Name (First, Middle, Last)  18. Mother's Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |      |                                                         |                                                                                 | (First, Middle, M                                          | (First, Middle, Maiden Surname)                                                                |                                                    |                                                    |  |
|                                            |                                                                                                                                                                                                                                                                                                  | Tol                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |      |                                                         |                                                                                 | e Wallace  Il Route Number, City or Town, State, Zip Code) |                                                                                                |                                                    |                                                    |  |
|                                            |                                                                                                                                                                                                                                                                                                  |                                      | 19a. Informant's Name/Relationship (Type. Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |
|                                            | s 1 an<br>of Heal<br>Item 2                                                                                                                                                                                                                                                                      |                                      | Ruth Parker— Wife 11411 Red Jade Court, Kettering, MD 20774  20a. Method of Disposition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |
| <u>iii</u>                                 | Page<br>ment a<br>ant: If<br>ury or                                                                                                                                                                                                                                                              |                                      | Southern Memorial    Southern Memorial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |
| Balt                                       | permit. Departi                                                                                                                                                                                                                                                                                  |                                      | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |
| Division or Vital Records, P.O. Box 68760, | Physician<br>/Medical                                                                                                                                                                                                                                                                            | 2                                    | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |
|                                            |                                                                                                                                                                                                                                                                                                  |                                      | Immediate Cause (Final disease or condition and Immediate (Final disease or condition and Immediate Cause (Final disease or condition and Immediate Cause (Final disease or condition and Immediate Cause (Final disease or condition and Immediate (Final disease or co |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |
|                                            | Examiner                                                                                                                                                                                                                                                                                         |                                      | Coronary Artery Disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |
|                                            | ding Physician: The law requires that the death certificate be executed h.  After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit                                                                      | ner                                  | Sequentially list conditions, if any, leading to firm ediate cause. Enter Underlying Cause (Disease or injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Due to (or as a consequence of):                                           |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |
|                                            |                                                                                                                                                                                                                                                                                                  | Examin                               | that initiated events                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | er Carcino                                                                 |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |
|                                            |                                                                                                                                                                                                                                                                                                  | Be Completed by Physician/Medical Ex | Hypertension                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |
|                                            |                                                                                                                                                                                                                                                                                                  |                                      | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome pf pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |      |                                                         |                                                                                 |                                                            | 23d. Date of delivery  Month Day Year                                                          |                                                    |                                                    |  |
|                                            |                                                                                                                                                                                                                                                                                                  |                                      | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Diabetes Mellitus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |      |                                                         |                                                                                 |                                                            | 23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown |                                                    |                                                    |  |
|                                            |                                                                                                                                                                                                                                                                                                  |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |      |                                                         |                                                                                 | 24a. Was a autop perfor                                    | in<br>sy<br>med?<br>2K No                                                                      | 24b. Were auto<br>prior to co<br>death?<br>1 □ Yes | opsy findings available impletion of cause of      |  |
|                                            |                                                                                                                                                                                                                                                                                                  |                                      | 25. Was case referred to medical an example of Death (Check only one)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |
|                                            |                                                                                                                                                                                                                                                                                                  | ို                                   | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Outlet: 4 Nursing Home 5 Residence 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    | fy)                                                |  |
|                                            |                                                                                                                                                                                                                                                                                                  | tion:                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 ☐ Yes 2 ☐ No |      |                                                         | 200. Describe flow injury occurred                                              |                                                            |                                                                                                |                                                    |                                                    |  |
|                                            | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune                                                                                                                                                                       | Certification:                       | 3 Suicide 6 Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |      |                                                         | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                                            |                                                                                                |                                                    |                                                    |  |
|                                            | To the Hospital within 24 hours of To the Funeral completely filled                                                                                                                                                                                                                              | Medical C                            | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |
|                                            | To th<br>within<br>To th<br>compi                                                                                                                                                                                                                                                                | Me                                   | 29b. Signature and title of certifier 29c. License number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |      |                                                         |                                                                                 |                                                            | 29d. Date signed (Month, Day, Year)                                                            |                                                    |                                                    |  |
|                                            | 15                                                                                                                                                                                                                                                                                               |                                      | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | week                                                                       |      | D5                                                      | 8957                                                                            |                                                            | c                                                                                              | 2-7-6                                              | 78                                                 |  |
| K                                          | 20. Name and address of person who completed cause of death (literar 2sa) (Typer Print)  Dr. Gary Little 300   Haspital Drive Okeverly MD 20785  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature                                                                               |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |      |                                                         |                                                                                 |                                                            |                                                                                                | 75                                                 |                                                    |  |
|                                            | St<br>Regist                                                                                                                                                                                                                                                                                     | ate<br>rar                           | 31. Date filed (Month, Day, Year) FEB 1 2 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 32. Registrar's Signatu                                                    | beek | -                                                       |                                                                                 |                                                            |                                                                                                |                                                    |                                                    |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8 **Physician** 12008 Purvis Cherv1 Karen ebruary /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Lanham Prince Georges 8. Date of Birth (Month, Day, Year) Apr. 15, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 🖫 F New York 075-50-3989 49 1958 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at X□Yes 2□No Greenbelt Director Md. Prince Georges 10f. Zip Code 20770 10e. Street and Number 10g. Citizen of What Country?
UNITED STATES 9181 Market Lane Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married Married Specify: Black 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 12th Housewife permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Faulkner Bessie Shearin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9181 Market Lane Greenbelt, Md. 20770 Russell Purvis (Husband) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/16/2008 Baltimore, Md. 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
W. H. Bacon Funeral Home, Inc.
3447 14th Street, N.W. Washington, DC 20010 21. Signature of Funeral Service Licenses con. CC361 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that o used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner a nome a Sequentially list conditions, if any, leading to immediate cause. Enter Univerying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner occulina attending physician and for use as the burial-tran Lor as a consequence of) Division or Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an certificate has autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State Registrar 29b. Signature and title of certifier

Fasil B. alemu

alems

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D65909

8118 GoodLuck Rd., Lanham, MD. 20706

29d. Date signed (Month, Day, Year)

218108

Amended items#10e,16b,19b/02/20/08,WCHD,SLU Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 1220 2008 Margaret M. Newton Poole 186 4c. County of Death 4a. Facility Name (If not institution, give street and num 4b. City. Town, or Location of Death Wicom. SALIS 6 UM 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) Days 1 □ M 2 🗓 F 213-16-8795 11-22-1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2√ No MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 805 Parkhurst Drive 614 Senior Way  $\frac{-21801}{}$  21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Dress Shop Elementary/Secondary (0-12) College (1-4or 5+) Factory Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Oran Murray Mamie Hopkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Boute Number, City of Town, State Zie Code) 805 Parkhurst Drive Salisbury, MD 21804 Harriett Bowen /Daughter 614 Senior 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Odd Fellows Cemetery 2-18-2008 Seaford Delaware 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bounds Funeral Home 705 E. Main Street, Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each, ne. Immediate Cause (Final disease or condition resulting in death) Arred Due to (or as a lonsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) (Specify) 27. Manner of Death 1 Natural 2 Accident 5 Pendii investi

**Physician** /Medical **Examiner** Examiner

Physiciañ

/Medical

**Funeral Director** 

à

Completed

Be

ဂ

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 20. . - any injury or other traumatic event, the Medical once.

attending physician this after death. in by the

Physician/Medical

2

Completed

Be

Certification: To

Medical

3 ☐ Suicide

29a Certifier

4 ☐ Homicide

29b. Signature and title of

Division or Vital Records, P.O. Box 68760.

Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital or within 24 hours aft To the Funeral Di completely filled in

DHMH 17 Rev 1/2001

23b. Was decedent pregnant

|               | Hospital: | 1 Inpatient                     | 2 🗆  | ER/Outpatient          | 3 🗆 [ | OOA  | Other: 4                      | I ☐ Nursing I | Home | 5 Residence       | 6 □Other     |
|---------------|-----------|---------------------------------|------|------------------------|-------|------|-------------------------------|---------------|------|-------------------|--------------|
| ng<br>igation | (         | Date of Injury<br>Month, Day Yo | ear) | 28b. Time of<br>Injury | М     | 28c. | Injury at<br>Work?<br>1 ☐ Yes | 2 🗆 No        | 28d. | Describe how inju | ury occurred |

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who com eted cause of death (Item 23a) (Type, Print)

Sulisbury Md. 21801 WELDERG 31. Date filed (Month, Day, Year) FEB 13 2008

State Registrar

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Carolyn H. Powell 9, 2008 10:20AM February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Lutheran Village Diven House Westminster 8. Date of Birth (Month, Day, Year) 8. 1914 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Min. 1 M 2 F Hours Maryland 93 212-05-6906 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natura!", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 28a-f show Carroll New Windsor 1 ☐ Yes 2X No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21776 3001 Merle Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No 3altimore, Maryland 21215-0036 Specify: white þ 3 MWidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 10 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Roth Annie Meeks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 Merle Court, New Windsor, MD 21776 Gay Lynn Schotta, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of I-important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/13/2008 Baltimore, MD Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home · K 91 Willis Street, Westminster, MD 21157 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician oronary Artery /Medical Due to (or as a conservence of): Examiner Hyperlipidamia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Chronic Renal Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as attending IF FEMALE: use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown for Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been sig 1 | Yes 2 | No 3 | Probably 4 | Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No , page certificate 2 **X** No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient မ 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

WJZ 4

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

Registrar DHMH 17 Rev 1/2001 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D6521

300 St. Luke Circle, westminster

29d. Date signed (Month, Day, Year)

Robrey Pitt 08-01323 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| INK UNK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | For State                                                              | f Maryland /                          | Depart<br>Certi           | tment of i<br>ificate of i          | Health a<br>Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | and M                         | lental Hy                       |                                  | g. No. 2                         | 108 0603                                         |
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| Physician/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | gistrar<br>Decedent's Name (First, Middle,Last)                        |                                       |                           |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                 | 2. Date of Deat                  | h                                | 3. Time of Death                                 |
| Medical Examine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | Rodney Rene' Pi                                                        | tt                                    |                           |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                 | February 1                       | 5, 2008                          | 1755 hrs                                         |
| 303                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4:             | a. Facility Name (if not institution, give                             | street and number)                    |                           | 41                                  | . City, Town<br>Baltimor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               | tion of Death                   |                                  | 4c. County of D                  |                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Ļ              | Johns Hopkins Hospital                                                 |                                       | /I I                      | a biabala A                         | If Under 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               | Under 24Hrs                     | 8 Date of Bir                    | Balti                            | MOTE  . Birthplace (State or                     |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1              | Social Security Number 6. Sex 1 31                                     | 7. Age                                | (In yrs. las<br>46        | Yrs.                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | Hours Min                       | _                                | F                                | oreign<br>Country) Germany                       |
| y.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | sual Residence of Decedent  Da. State 10b. County                      |                                       | 10c. City. T              | own or Location                     | on.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               |                                 |                                  |                                  | 10d. Inside City Limits                          |
| ow any                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1"             | MD Carolin                                                             | I                                     |                           |                                     | Federa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | alsbi                         | uro                             |                                  |                                  | 1 XYes 2 No                                      |
| yland a-f she tonce                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <u> </u>       | De. Street and Number                                                  |                                       |                           |                                     | 10f. Zip Co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                               | 41.6                            | 1                                | 0g. Citizen of What              | Country?                                         |
| more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland not of Health 1s and Mental Hygiene. Intel If litem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | 117 Greenridge I                                                       |                                       |                           |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1632                          |                                 |                                  |                                  | States American Indian, Black,                   |
| or items 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1              | Marital Status     Never Married 2 Married                             | 12. Was Decedent<br>Armed Forces?     |                           | 5. 13. Was                          | Decedent on the Decedent of th | it Hispan<br>uban, <b>M</b> e | ic Origin? (S<br>exican, Puerto | pecify Yes or No<br>Rican, etc.) | White, e                         |                                                  |
| or its                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 3              |                                                                        | 1 Yes 2                               | X No                      | 1                                   | Yes 2 X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | No sr                         | pecify:                         |                                  | Specify:                         | Black                                            |
| hours after fractural".  Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <u> </u>       | Widowed 4 Divorced  15. Decedent's Education (Specify onl              | or Dates:                             | pleted)                   | 16a, Decedent                       | 's Usual Occ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | cupation                      | (Give kind of                   | work done                        | 16b. Kind of Busin               |                                                  |
| 2 hour "nate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                | Elementary/Secondary (0-12)                                            | College (1-4 or 5                     |                           | during mo                           | st of working                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | g life. DC                    | NOT use ret                     | ired)                            |                                  |                                                  |
| hin 7. than edical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 5              | 11                                                                     |                                       |                           | Cons                                | struct                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ion                           | Worker                          |                                  | Const                            | ruction                                          |
| 21215-0036 Judd be filed within 72 hour Mental Hygiene, marked other than "nature event, the Medical Exan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 3 1            | 7. Father's Name (First, Middle, Last)                                 |                                       |                           |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                 | ,                                | Maiden Surname)                  |                                                  |
| 2121;<br>uld be fill<br>Mental F<br>marked<br>c event,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 8              | Fletcher Pitt                                                          |                                       |                           |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                 |                                  | Vickers                          | State Zin Code)                                  |
| 221<br>hould<br>ad Me<br>is ma<br>ritic ev                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2 1            | 9a. Informant's Name/Relationship (Ty                                  |                                       |                           | 1                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                 |                                  | mber, City or Town,              |                                                  |
| more, MD   Pages 1 and 2 shorent of Health and unt: If item 27 is ir other traumating.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | L              | Catherine Vicker Oa. Method of Disposition                             | s/Mother                              | 20h P                     | 117 (<br>Place of Disposi           | reenr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | idge<br>of cernete            | Rd F                            | <u>ederals</u><br>Date           | burg MD 20c. Location - C        | City or Town, State                              |
| ore,<br>es 1 ar<br>of Her<br>of Her tr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1              | 1 Burial 2 X Cremation 3                                               | Removal from Sta                      | ate c                     | rematory or oth                     | er place)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                               | 2/                              | 23/08                            | Dwaston                          | MD 21655                                         |
| Page<br>ment<br>tant:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | 4 Donation 5 Other Specify:                                            |                                       | Mt.                       | Pleasar                             | it Cem                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | eter                          | y                               |                                  | Preston                          |                                                  |
| Baltimore,<br>permit. Pages I ar<br>Department of Hed<br>Important: If ite<br>injury or other tr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 12             | 1. Signature of Funeral Service Licens                                 | n Coa                                 | la                        | 216                                 | N. M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ain                           | St. Fe                          | amptom<br>deralsb                | Funeral H<br>urg, MD             | ome, PA  <br>21632                               |
| Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | - 2            | 3a. Part I. Enter the disease, or compl                                | cations that caused                   | the death.                | Do not enter th                     | ne mode of o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | lying, suc                    | ch as cardiac                   | or respiratory ar                | rest, shock, or hear             | t Approximate Interval<br>Between Onset and      |
| Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | failure. List only one cause on ear<br>mmediate Cause (Final disease a | Asthma                                |                           |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                 |                                  |                                  | Death                                            |
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| to be executed ysician and burial - transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | edical         | X UNPENDED                                                             | AMENDED 23a                           |                           |                                     | 4/10/0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 18 amb                        | n                               |                                  | 20d Date of a                    | lalivon:                                         |
| certificate ording physise as the brise as t |                | F FEMALE:<br>3b. Was decedent pregnant in the                          | 23c. If yes, outcom                   | me of pregr               |                                     | etal death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 3                             | Ectopic preg                    | nancy                            | 23d. Date of d<br>Month          | Day Year                                         |
| certification is as as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ciar           | past 12 months?                                                        | 4 Pregnant a                          | t time of de              | - db                                | ther (Specif                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               | ,                               |                                  |                                  |                                                  |
| Box 6876 e death certificate the attending phy ed for use as the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | >l             | 1 Yes 2 No 9 Unknown                                                   | 9 Ulknown                             | _                         |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                 |                                  |                                  | to to the source of death?                       |
| Records, P.O. Box The law requires that the death icate has been signed by the atte page 2 should be detached for the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | Part II. Other significant conditions                                  | contributing to deal                  | th but not re             | esulting in the                     | underlying c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ause give                     | en in Part I.                   |                                  |                                  | oute to the cause of death?  Probably 4  Unknown |
| Division of Vital Records, P.O. rial or Attending Physician: The law requires that the rs after death.  "al Director: After this certificate has been signed by left in by the funeral director, page 2 should be detached in by the funeral director, page 2.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | g p            |                                                                        |                                       |                           |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                 | 24a. Wa                          |                                  | Vere autopsy findings available                  |
| ords<br>v requisional                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Completed      |                                                                        |                                       |                           |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                 | aut                              | opsy pr                          | rior to completion of cause of eath?             |
| ecc<br>he lav                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Ē              |                                                                        |                                       |                           |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                 |                                  |                                  | Yes 2 No                                         |
| an: T                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Be C           | 25. Was case referred to medical                                       |                                       |                           |                                     | 26                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               | f Death (Chec                   |                                  |                                  | 7                                                |
| Vita<br>hysici<br>this c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 0              | 1 ✓ Yes 2 No                                                           |                                       |                           | ER/Outpatien                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ,,                            |                                 | sing Home 5                      | Residence 6 e how injury occurre | Other:                                           |
| n of ing Pl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Ë              | 27. Manner of Death  1 X Natural 5 Pending                             | 28a. Date of Inj<br>(Month, Day,      | jury<br>Year)             | 28b. Time of                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | at Work?<br>s 2 No              | Zod. Describ                     | e now injury occurre             | su .                                             |
| ttend<br>teath.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <u>ä</u>       | 2 Accident Pending Investigati                                         | on                                    |                           |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                 | 28f Location                     | (Street and Number               | er or Rural Route Number, City                   |
| lor A after of Direct Jin by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Certification: | 3 Suicide 6 Could not determine                                        |                                       | njury - At h              | ome, tarm, stre                     | et, factory, c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | omice bui                     | iding, etc.                     | or Town                          |                                  | or trains mode managery                          |
| Divis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ١ق             | 4 Homicide                                                             | (0),000,00                            |                           |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | and place of                    | nd due to the ca                 | use(s) and manner                | as stated.                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine  | ian: To the best of r                 | ny knowied<br>amination a | ige, death occu<br>and/or investiga | ation, in my                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | pinion, o                     | death occurre                   | d at the time, da                | te and place, and d              | ue to the cause(s)                               |
| To the within To the comp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Medical        | 29b. Signature and title of certifier                                  | and manner stated                     | d                         |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | License                       |                                 |                                  |                                  | ed (Month, Day, Year)                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | -              | 200. Signature and the or dorand                                       | 100                                   | n                         |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | O.C.M                         | .E.                             |                                  | February 1                       | 6, 2008                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 10VIL                                                                  | sompleted as As at                    | doub the                  | n 23a)                              | l                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               |                                 |                                  |                                  |                                                  |
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| Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | nt e           | 31. Date filed (Month, Day, Year)                                      | 32. Registr                           |                           |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                 |                                  |                                  |                                                  |
| Registi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                |                                                                        |                                       |                           |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                 |                                  |                                  |                                                  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 2008 eb /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Maryland 6. Sex of Iniversity (enter timore redical None Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Director 629-01-2592 63 Mexico Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits ıral", or items 23a or 28a-f show Examiner must be notified at Director 1 Tyes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5506 Phelps Luck Drive 21045 Funeral Mexico 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 N Married 1 X Yes 2 ☐ No Specify: Mexican ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Golf Course Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesus Perez Lorenza Almendariz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Carmen Perez (Spouse) 5506 Phelps Luck Drive, Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any Injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) All Souls Cemetery 2/15/08 Germantwon, Maryland 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee ober 23a. Pa 1. Enter the diseal com shock, heart failure. List only Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Myclodys lastic /Medical Examiner 10 fibrosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be execut physician and s the burial-trans Infection Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown certificate has been signed by rector, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes or Attending Physician: funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attence within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Feb 8 2008 Myda P21212 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 22. Registrar's Signature

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|                                     | E. E                                                                                                                          |                | Registrar  1. Decedent's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 001                            | inicate or beatin                                                              | 2. Date of                                 |                           | ~ ~ 0 0 0                              | 3. Time of Beath                                   |
|                                     | Physicia                                                                                                                      | an             | Charles Joseph Petronis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                |                                                                                | Month<br>Febru                             | _                         | year Year <b>2008</b>                  | 6:35a <sup>M</sup>                                 |
|                                     | /Medic<br>Examin                                                                                                              |                | 4a. Facility Name (If not institution, give street and number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                | 4b. City, Town, or Location                                                    | of Death                                   | 4                         | c. County of Death                     |                                                    |
|                                     |                                                                                                                               |                | Montgomery Hospice-Casey Hous                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                | Rockville                                                                      | OALIna Ta B                                | 1.00                      |                                        | tgomery                                            |
|                                     | Funeral                                                                                                                       |                | 5. Social Security Number 6. Sex 7. Age (In yrs. I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ast birthday)<br>Yrs.          | If Under 1 Year If Under Months Days Hours                                     | Min. (Monti                                | n, Day, Yea               | r) Cou                                 | place (State or Foreign<br>intry)                  |
|                                     | Director                                                                                                                      | -              | 128-28-9917 69 Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                |                                                                                | Marci                                      | 2, 1                      | 1930 New                               | York                                               |
|                                     | yland<br>low<br>at                                                                                                            | - 1            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | , Town or Lo                   | cation                                                                         |                                            |                           |                                        | 10d. Inside City Limits                            |
|                                     | a-f sh                                                                                                                        | cgo            | Maryland Montgomery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | F                              | Rockville                                                                      |                                            |                           |                                        | 1 □ Yes 2 □ No                                     |
|                                     | or 28                                                                                                                         | Director       | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                | 10f. Zip Code                                                                  |                                            | 10g. C                    | Citizen of What Cou                    | untry?                                             |
|                                     | 172 hours after death with the Maryland<br>"natural", or items 23a or 28a-f show<br>dical Examiner must be notified at        |                | 16504 Jilrick Street  11 Marital Status 12. Was Decedent Ever in U.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | e   12 1                       | 20853                                                                          | inin? /Specify Ves                         | or No-                    | USA<br>14. Race - Amer                 | ican Indian,                                       |
|                                     | items<br>items<br>iner n                                                                                                      | Funeral        | 11. Marital Status  1 ☐ Never Married 2 Married   1 ☐ Maries   1 ☐ Ma |                                | Was Decedent of Hispanic Or<br>If Yes, specify Cuban, Mexica                   | in, Puerto Rican, etc                      | i.)                       | Black, White                           | , etc.                                             |
| ည                                   | urs af<br>al", or<br>xami                                                                                                     | ρ              | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1960 —                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 83                             | 1 ☐ Yes 2 € No Specify                                                         | •                                          |                           | Specify: W                             | hite                                               |
| 500-612                             | 72 hol<br>natura<br>lical E                                                                                                   | Completed      | 15. Decedent's Education<br>(Specify only highest grade completed)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 16a. Dece                      | dent's Usual Occupation<br>kind of work done during mos<br>DO NOT use retired) | st of working                              | 16b.                      | Kind of Business/I                     | ndustry                                            |
| V                                   | ithin<br>ne.<br>nan "                                                                                                         | apple 1        | Elementary/Secondary (0-12) College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | life.                          |                                                                                |                                            |                           | IIC 3                                  |                                                    |
| 7                                   | i filed within 72 h<br>I Hygiene.<br>other than "nati<br>rent, the Medica                                                     |                | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                | Lt. Colonel                                                                    | er's Name (First, M                        | iddle, Maide              | US Arı<br>en Surname)                  | my                                                 |
| 2                                   | e d ta                                                                                                                        | o Be           | Frank J. Petronis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                | Eliza                                                                          | beth Fox                                   |                           |                                        |                                                    |
| Maryland                            | d 2 should Ith and Men 7 is marke traumatic                                                                                   | Ĕ              | 19a. Informant's Name/Relationship (Type. Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 19b. Mailir                    | ng Address (Street and Numb                                                    | per or Rural Route N                       | lumber, City              | y or Town, State, Z                    | ip Code)                                           |
|                                     | S is a                                                                                                                        |                | Elizabeth Petronis/Wife                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1                              | 6504 Jilrick                                                                   | Street, R                                  | ockvi                     | .11e, MD :                             | 20853                                              |
| aitimore,                           | - I 9 €                                                                                                                       |                | 20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Removal from State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Place of Dispo<br>emetery, cre | osition (Name of matory or other place)                                        | April 2,                                   | 20c.                      | Location - City or                     | Town, State                                        |
| Ĕ                                   | Pages<br>ment of<br>ant: If it                                                                                                |                | 4 Donation 5 Other (Specify) Ar1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                | National                                                                       | 2008                                       |                           | ington,                                | Virginia                                           |
| gall                                | permit. Pag<br>Department<br>Important: I<br>any Injury o<br>once.                                                            |                | 21. Signature of Funeral Service Licensee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ral H<br>, Sil                 | ome Inc.<br>ver Spri                                                           | ng, MD 20901                               |                           |                                        |                                                    |
| ű                                   | ELECTION 1                                                                                                                    |                | 23a. Part1. Enter the disease, or con plic tions that caused the death shock, or heart failure. List only on- cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | h. Do not en                   | ter the mode of dying, such a                                                  | s cardiac or respirat                      | ory arrest,               |                                        | Approximate<br>Interval Between<br>Onset and Death |
|                                     | Physician                                                                                                                     | 9 9            | Immediate Cause (Final disease or condition a. Glioblastom                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 3                              |                                                                                |                                            |                           |                                        | Oliset and Death                                   |
| /a.                                 | /Medical<br>Examiner                                                                                                          |                | resulting in death)  Due to (or as a conseq                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                |                                                                                |                                            |                           |                                        |                                                    |
|                                     |                                                                                                                               | er             | Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseq                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | uence of):                     |                                                                                |                                            |                           |                                        |                                                    |
|                                     | uted<br>I<br>Insit                                                                                                            | min            | Cause. Enter Underlying Cause (Disease or injury that initiated events  c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ŕ                              |                                                                                |                                            |                           |                                        |                                                    |
| o Î                                 | exection and and rial-tra                                                                                                     | Examin         | resulting in death) Last Due to (or as a conseq                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | uence of):                     |                                                                                |                                            |                           |                                        | -                                                  |
| 8/60,                               | icate be executed<br>physician and<br>s the burial-transit                                                                    | dical          | d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                |                                                                                |                                            |                           |                                        |                                                    |
| 9                                   | ertifica<br>ing ph<br>e as t                                                                                                  |                | IF FEMALE:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                |                                                                                |                                            | _                         |                                        |                                                    |
| Division or Vital Records, P.O. Box | The law requires that the death certifice has been signed by the attending tage 2 should be detached for use as               | Physician/M    | 23b. Was decedent pregnant in the past 12 months?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | l death 3                      | ☐Ectopic pregnancy<br>☐ Other (specify)                                        |                                            |                           | 23d. Date of del                       | Day Year                                           |
| O                                   | the de                                                                                                                        | ysic           | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | leatii J                       |                                                                                |                                            |                           |                                        |                                                    |
| J.                                  | that hed by detail                                                                                                            |                | Part II. Other significant conditions contributing to death but not res                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ulting in the u                | underlying cause given in Part                                                 | :I. 23e.                                   | Did tobacc                | co use contribute to                   | the cause of death?                                |
| ras                                 | quires<br>in sign                                                                                                             | ed by          | Pneumonia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                |                                                                                |                                            | 1 ☐ Yes                   | 2 No 3 Pi                              | robably 4x Unknown                                 |
| ပ္က                                 | aw requir<br>is been si<br>2 should I                                                                                         | Completed      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                |                                                                                | 24a.                                       | Was an autopsy            | 24b. Were au                           | utopsy findings available completion of cause of   |
| Ĭ                                   | The lav                                                                                                                       | mo;            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                |                                                                                | 1_                                         | performed<br>Yes 2 🙀      | ? death?                               | 2 □ No                                             |
| <u>Ea</u>                           | ician: Th<br>certificate<br>ector, pag                                                                                        | Be             | 25. Was case referred to medical examiner?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                |                                                                                | ce of Death Check                          | onl one                   |                                        | _                                                  |
| 7                                   | ding Physician: n. After this certific funeral director,                                                                      | 은              | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ER/Outpatie                    |                                                                                |                                            | _                         | e 6 Other (Spe                         | ecify)Hospice                                      |
| U<br>C                              | Jing F                                                                                                                        | ion;           | 27. Manner of Death  M Natural 5 □ Pending (Month, Day Year)  2 □ Accident investigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Injury                         | of 28c. Injury at Work?  M 1 ☐ Yes 2 [                                         |                                            | Clibe HOW II              | njury occurred                         |                                                    |
| <u>s</u>                            | death<br>death<br>ctor:<br>y the                                                                                              | icat           | 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At h                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ome, farm, st                  |                                                                                | 28f. Loca                                  | tion (Street              | t and Number or R                      | ural Route Number,                                 |
| 2                                   | after<br>after<br>Dire                                                                                                        | Certification: | 4 ☐ Homicide determined building, etc. (Speci-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | fy)                            |                                                                                | City                                       | or Town, S                | tate)                                  |                                                    |
|                                     | To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer |                | 29a. Certifier 1 ☑ Certifying Physician: To the best of my kno (Check only 2 ☐ Medical Examiner: On the basis of examina                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | owledge, dea<br>ation and/or i | th occurred at the time, date nvestigation, in my opinion, d                   | and place, and due<br>eath occurred at the | to the caus<br>time, date | e(s) and manner a<br>and place, and du | s stated.<br>e to the cause(s)                     |
|                                     | the I                                                                                                                         | Medical        | one) and manner stated.  29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                | 29c. License number                                                            |                                            |                           | Date signed (Mon:                      |                                                    |
|                                     | 1 / S = \$ 5   \$                                                                                                             |                | Survive WW/06-15                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | hes                            | D64615                                                                         |                                            |                           | ebruary                                |                                                    |
| 1                                   | 124                                                                                                                           |                | 30. Name and address of person who completed cause of death (Itel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | m 23a) (Type                   | . Print)                                                                       | -                                          |                           |                                        |                                                    |
| _                                   |                                                                                                                               |                | Genevieve Wroblewski, MD 60                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 01 Mun                         |                                                                                | toad, Rock                                 | ville                     | , MD 208                               | 55                                                 |
|                                     | St<br>Regist                                                                                                                  | ate<br>rar     | 31. Date filed (Month, Day, Year) 32. Registrar's Sign FEB 1 2 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ature                          | and a                                                                          |                                            |                           |                                        |                                                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend Item 26 per dvr 9876 2-26-08 vt
State of Maryland 7 Department of Health and Mental Hygiene State State Registrar #29d, 2/11/08, Per physiciane rtificate of Death E.T, WCHD Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:43 AM **Physician** February 9, Pusey 2008 Mabel R. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomico Golden Gardens Assisted Living Parsonsburg 8. Date of Birth (Month, Day, Year) 3/5/1917 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2**K**) F Maryland 214-28-1697 90 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County an "naturai", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Snow Hill Maryland Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21863 208 Coulbourne Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: white Specify þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) the domestic Homemaker 11 other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Sadie Taylor Isaac J. Hancock 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 208 Coulbourne Lane, Snow Hill, MD 21863 Betty Hitch/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/13/08 Stockton, MD Portersville Cemetery Hoffoway Funeral Home Professional Associaiton 103 Linden Ave., Pocomoke City, MD 21851 21 Stopature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final your **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) signed by the a d be detached fi 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? (es certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Other (Specify) assisted 1 ☐ Yes 3□ DOA 1 Inpatient 2 ER/Outpatient 2 this living completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After the Funeral Director of the foundation of the f Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 036576 2/11/2008 30. Name and addr of person who completed cause death (Item 23a) (Type, Print) ?-560 RIVENSIDE DR 1844 ITE WE RONX 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

|                |                                                                                                                        |                | 1 - Stata<br>Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | State of Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | -                              | irtment of H<br>tificate of I                                              |                                                         |                                     | ene<br>g. No. 2 11 11 9                          | 06043                                                   |
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|                | Physici                                                                                                                | an             | 1. Decedent's Name (First, Middle, La                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                                                                            |                                                         | 2. Date of Death<br>Month           | Day Year                                         | 3. Time of Death                                        |
|                | /Medic                                                                                                                 | al             | MARY LERO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | QUINTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                | 4h Cihi Taum ai                                                            | Location of Death                                       | FEBRUAI                             | 4c. County of Deat                               |                                                         |
|                | Examin                                                                                                                 | er             | 4a. Facility Name (If not institution, give Brocke Grove Rebabili                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Center                         | Sandy                                                                      | Spring                                                  |                                     | Montga                                           |                                                         |
|                | Funeral                                                                                                                |                | Social Security Number 6. 9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Sex 7. Age (In yrs. I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                | If Under 1 Year<br>Months Days                                             | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Birth<br>(Month, Day,    | 9. Bir                                           | thplace (State or Foreign                               |
|                | Director                                                                                                               |                | 220-40-0992                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1 □ M 2 🖾 F 9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 6 Yrs.                         | World Days                                                                 | 114414                                                  |                                     |                                                  | nington, DC                                             |
|                | and *                                                                                                                  | }              | Usual Residence of Decedent  10a. State 10b. County                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 10c. City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | , Town or Lo                   | cation                                                                     |                                                         |                                     |                                                  | 10d. Inside City Limits                                 |
|                | Maryl.                                                                                                                 | ō              | Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Montgomery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | D                              | ockville                                                                   |                                                         |                                     |                                                  | 1 ☐ Yes 2 ☐ No                                          |
|                | r 28.                                                                                                                  | Director       | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Horregomery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                | 10f. Zip Code                                                              |                                                         | 10                                  | g. Citizen of What Co                            | ountry?                                                 |
|                | th with                                                                                                                |                | 13814 Arctic Av                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | renue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                | 20853                                                                      |                                                         |                                     | USA                                              |                                                         |
| 36             | 172 hours after deeth with the Maryland<br>*naturel; or Iteme 23e or 28e-f ehow<br>idical Examinat must be notified at | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 12. Was Decedent Ever in U.: Armed Forces? 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | '                              | Was Decedent <i>o</i> f H<br>f Yes, specify Cuba<br>I □ Yes 2√2 N <i>o</i> | ispanic Origin? (Spo<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)    | 14. Race - Ame<br>Black, White<br>Specify: White | te, etc.                                                |
| 21215-0036     | 22<br>E E                                                                                                              | Completed t    | 15. Decedent's E<br>(Specify only highest gr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ducation<br>ade completed)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 16a. Deced<br>(Give<br>life. I | tent's Usual Occup<br>kind of work done<br>OO NOT use retired              | ation<br>during most of work                            | ing                                 | 6b. Kind of Business                             | /Industry                                               |
| 212            | d within<br>plene.<br>r then                                                                                           | mo             | Elementary/Secondary (0-12)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Но                             | memaker                                                                    |                                                         |                                     | Own Hor                                          | ne                                                      |
|                | be filed<br>ntal Hygi<br>od other<br>event, I                                                                          | BeC            | 17. Father's Name (First, Middle, Las                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                |                                                                            | 18. Mother's Name                                       | (First, Middle, M                   | faiden Sumame)                                   |                                                         |
| yla            | ould by<br>Menta<br>Marked                                                                                             | 2              | Claude S. Carper                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                                                                            |                                                         | E. Huck                             |                                                  |                                                         |
| Maryland       | and                                                                                |                | 19a. Informant's Name/Relationship William K. Ouint                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                                                                            |                                                         |                                     | City or Town, State,                             |                                                         |
|                | f Health<br>item 27<br>other tr                                                                                        |                | 20a. Method of Disposition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 20b. P                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | lace of Dispo                  | sition (Name of                                                            |                                                         |                                     | e, MD 2085<br>20c. Location - City or            |                                                         |
| nor            | S = = 0                                                                                                                |                | \$□ Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Special Control | Hemoval from State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | · ·                            | natory`or other plac<br>eaven Cer                                          | re                                                      |                                     | ilvor Spri                                       | ing, Maryland                                           |
| Baltimore,     | permit. Pege<br>Department of<br>Importent: If<br>eny injury or<br>once.                                               |                | 21. Signature of Funeral Service Lice                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | -37                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 22<br>F                        | Name and Addre                                                             | ss of Facility Collins                                  | Funeral                             | Home Inc.<br>lver Sprir                          |                                                         |
|                |                                                                                                                        |                | 23a. Part1. Enter the disease, or cor<br>shock, or heart failure. List only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | polications that caused the death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                |                                                                            |                                                         |                                     |                                                  | Approximate<br>Interval Between                         |
|                | Physician                                                                                                              |                | Immediate Cause (Final disease or condition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Onset and Death                |                                                                            |                                                         |                                     |                                                  |                                                         |
|                | /Medical                                                                                                               |                | resulting in death)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | a. hypernatre Due to (or as a consequ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | uence of):                     | City                                                                       |                                                         |                                     |                                                  | 1                                                       |
| Н              | Examiner                                                                                                               |                | Sequentially list conditions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | , dysphagia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                |                                                                            |                                                         |                                     |                                                  | days                                                    |
|                | 9d<br>Sit                                                                                                              | luei           | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Due to (or as a nsequence of a local control of a l |                                | - 000                                                                      | + ه ص ال                                                |                                     |                                                  | 5 days                                                  |
|                | be executed<br>sicien and<br>burial-transit                                                                            | Examin         | that initiated events<br>resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | c. Due to (or as a consequ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | uence of):                     | 1 MCZ 16                                                                   |                                                         |                                     |                                                  | 5 4 5                                                   |
| 8760,          | the by the                                                                                                             | dical          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | c. CEVELOTOVAS  Due to (or as a consequence)  d. CEVELOTOVA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | scul                           | ar dis                                                                     | ease                                                    |                                     |                                                  | Years                                                   |
| Box 6          | eath certifi<br>attending  <br>for use as                                                                              | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 23c. If yes, outcome of pregna<br>1 □ Live birth 2 □ Fetal<br>4 □ Pregnant at time of do<br>9 □ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | death 3                        | Ectopic pregnance Other (specify)                                          | 1                                                       |                                     | 23d. Date of de<br>Month                         | olivery<br>Day Year                                     |
| rds, P.O       | quires thet the d<br>n signed by the<br>uld be detached                                                                | ۵              | Part II. Other significant conditions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | contributing to death but not rest                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ulting in the u                | nderlying cause gro                                                        | ren în Part I.                                          |                                     |                                                  | to the cause of death?<br>Probably 4 Munknown           |
| Vital Records, |                                                                                                                        | Completed      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                                                                            |                                                         | 24a. Was a autops perform           | 24b. Were a prior to death?                      | utopsy findings available completion of cause of s 2 No |
| /ita           | sicien: Th<br>certificate<br>rector, pag                                                                               | Be             | 25. Was case referred to medical examiner?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Ha-shali                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                |                                                                            | 26. Place of Deat                                       |                                     |                                                  |                                                         |
|                | Phys<br>this<br>aldi                                                                                                   | 2              | 1 ☐ Yes 2 No 27. Manner of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Hospital: 1 Inpatient 2 Inpatient 2 Inpatient 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ER/Outpatier<br>28b. Time o    | I 3 DOA                                                                    |                                                         |                                     | ence 6 Other (Sp<br>ow injury occurred           | ecify)                                                  |
| G              | ling<br>After<br>Tune                                                                                                  | tlon           | 1 Natural 5 ☐ Pending                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (Month, Day Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Injury                         | Wo                                                                         | rk?<br>Yes 2 No                                         | 250. 56361156 116                   | Williamy Goodings                                |                                                         |
| Division of    | i or Attending<br>atter death.<br>Director: Atter<br>I in by the fune                                                  | Certification: | 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | be 29a Bloss of Injury Al ha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                | reet, factory, office                                                      |                                                         | 28f. Location (St<br>City or Town   | reet and Number or F<br>n, State)                | Rural Route Number,                                     |
|                | To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the 1           | Medical C      | 29a. Certifier Cartifying F (Check only 2 Medical Exa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | hysician: To the best of my kno<br>minar: On the basis of examina<br>and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | wledge, deat<br>tion and/or in | h occurred at the ti<br>vestigation, in my o                               | me, date and place,<br>opinion, death occur             | and due to the cared at the time, d | ause(s) and manner a<br>ate and place, and du    | as stated.<br>ue to the cause(s)                        |
|                | To the<br>Within<br>To the                                                                                             | Me             | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                | 29c. Licens                                                                | se number                                               | 2                                   | 9d. Date signed (Mor                             | nth, Day, Year)                                         |
|                |                                                                                                                        |                | I Commo S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TATT PHYSICIAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | د                              | DY                                                                         | 2046                                                    | 1                                   | ebruary                                          | 7,2008                                                  |
|                | 10 (4)                                                                                                                 |                | 30. Name and address of person who Grace Brooks Huf                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | completed cause of death (Item                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 0 Slac                         | Print)<br>Le School                                                        | Road So                                                 | indy Spr                            | ing Marylan                                      | N 20860                                                 |
|                | Sta<br>Regist                                                                                                          |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 32 Registrar's Signa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ture                           | action                                                                     |                                                         |                                     |                                                  |                                                         |
|                | negist                                                                                                                 | i.i.           | LED TO 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | JULY KIRKEL K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Par                            | to All                                 |                                                         |                                     |                                                  |                                                         |

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 4:25 PM Eric Wayne Ryan February 16 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 2421 Trevanion Road Taneytown Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. April 30, 1962 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Mary land 45 Yrs 215-76-4912 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Mentinal Examples. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 No Carroll Maryland Taneytown Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 2421 Trevanion Road 21787 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction City Govt. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry W. Ryan, Jr. Dolores Remsburg 2 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Morrissey/mother 2421 Trevanion Road Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chapel Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Feb. 21,2008 Libertytown, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of funeral Service Licens 22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Road Libertytown, MD 23a. Part1. Enter the disease, or complications that caused the de vh. Dy lot enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** las /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 1 No 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural s after deau.
rai Director: Aft 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in within 24 hours a the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar DHMH 17 Rev 1/2001 30. Name and address

31. Date filed (Month, Day, Year)

person who

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** REAVES FEBRUARY 9 2008 8:52 P Α. BEATRICE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🙀 F 74 577-54-1957 JAN 14 1934 NORTH CAROLINA Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits show 10a. State a 1X Yes 2 No "natural", or Items 23a or 28a-f st idical Examiner must be notified Director FORESTVILLE PRINCE GEORGE'S MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA the Medical Examiner must be 20747 2611 LUANA DRIVE # 101 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ď No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, filed within 72 hours after 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOUSE WIFE permit. Pages 1 and 2 should be filled win Department of Health and Mental Hygien Important; if Item 27 Is marked other this any injury or other traumatic mane. 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALSTON NANNIE OLAARRINGTON ALBERT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LUANA DR # 101 FORESTVILLE, MARYLAND 20747 MACK REAVES JR./HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State CHELTENHAM, MARYLAND MD VETERANS CEMETERY 2/25/08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL RORE 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine order cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the use 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 PER/Outpatient 3 DOA 1 Inpatient ို 1 Tyes this 27. May r of Death completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After (Month, Day Year) Injury 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 29a Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and t

State Registrar 31. Date filed (Month, Day, Year) 2008 1



mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) FEB Month Day Year **Physician** NWOON 0752 AM 0 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE OF MARYLAND MENICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex. 1 M M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day **Funeral** Days Hours Months Maryland Director 220-28-2430 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 Yes 2 No Susse X **Funeral Director** Scatora 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2270 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must b 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 2 No 1 🗌 Yes Black Completed by 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surr, 17 Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ross dge Rd. Seaford Hausta 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 3 Removal from State 1 Burial 2 □ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 23a. Par1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is only one cause on each line. ALUEDLAR HEMMORAGE **Physician** /Medical Due to (or as a consequence of): Examiner (TOMERULO NEPHAITIS NECROPFING ESLENTERIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the a 9 Unknown ate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes No certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Septifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifier 1225246077 108 KOV: TZ and address of person who completed cause of death (Item 23a) (Type, Print) GREENE ST BALTIMORE

State Registrar 31. Date filed (Month, Day, Year) FEB 13 2008

DHMH 17 Rev 1/2001

21201

| 08-01367<br>Justin Dwayne Ro                                                                                                                                                                                                                                                                                                                                | lone            | Please Type or Print in Black Indelible State of Maryland / Departmen                                                     | le Ink. Ensure All                                          | Copies Arental Hygier                  | e Legible<br>ne                        | е.                          |                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|---------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------|----------------------------------------|-----------------------------|----------------------------------------------------|
| Justili Dwayne Ro                                                                                                                                                                                                                                                                                                                                           | 1-              | For State Certificate                                                                                                     | e of Death                                                  |                                        | Reg. No.                               | 20                          | 08 0604                                            |
| Physician                                                                                                                                                                                                                                                                                                                                                   |                 | poistrar Decedent's Name (First, Middle,Last)                                                                             |                                                             | 2. Date<br>Mor                         | e of Death<br>orth Day<br>oruary 16, 2 | Year                        | 3. Time of Death<br>1422 hrs                       |
| Medical Examine                                                                                                                                                                                                                                                                                                                                             | er              | Justin Dwayne Roland a. Facility Name (if not institution, give street and number)                                        | 4b. City, Town, or Location                                 |                                        | ruary 16, 2                            | c. County of Dea            |                                                    |
| 4                                                                                                                                                                                                                                                                                                                                                           | 4               | a. Facility Name (if not institution, give street and number)  9513 Livingston Road                                       | Oxon Hill                                                   |                                        |                                        | Prince Georg                |                                                    |
| Funeral                                                                                                                                                                                                                                                                                                                                                     |                 | Social Security Number 6. Sex 7. Age (In yrs. last birthd                                                                 |                                                             |                                        | ate of Birth(MM                        | 1Fore                       | Birthplace (State or<br>eign                       |
| Director                                                                                                                                                                                                                                                                                                                                                    | - 1             | 18-13-8052 1XM 2F 35                                                                                                      | Yrs. Months Days Ho                                         | ours Min. Ma                           | y 6, 19                                | 72 °                        | Country) MD.                                       |
|                                                                                                                                                                                                                                                                                                                                                             | Ū               | Isual Residence of Decedent                                                                                               | Location                                                    |                                        |                                        |                             | 10d. Inside City Limits                            |
| w any                                                                                                                                                                                                                                                                                                                                                       |                 | ua. State                                                                                                                 |                                                             |                                        |                                        |                             | 1 XXYes 2 No                                       |
| yland yland                                                                                                                                                                                                                                                                                                                                                 | ğΜ              | aryland Charles Waldo                                                                                                     | 10f. Zip Code                                               |                                        | 10g. C                                 | tizen of What Co            | ountry?                                            |
| or 28s                                                                                                                                                                                                                                                                                                                                                      | ire             |                                                                                                                           | 20602                                                       |                                        | US                                     |                             |                                                    |
| 215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. Red other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at once.                                                                                                                                                                       | ᅙ               | 1. Marital States                                                                                                         | 13. Was Decedent of Hispanic<br>If Yes, specify Cuban, Mexi | Origin? (Specify                       | Yes or No-<br>. etc.)                  | 14. Race - Am<br>White, etc | erican Indian, Black,                              |
| death or item                                                                                                                                                                                                                                                                                                                                               | <u>e</u>        | 1 XX Never Married 2 Married Armed Forces? 1 Yes 2 XX No                                                                  | 1 Yes 2 X No spe                                            |                                        | •                                      | Specify: Wh                 | ite                                                |
| after<br>ral", o                                                                                                                                                                                                                                                                                                                                            | <u>a</u>        | Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Do   | ecedent's Usual Occupation (G                               | Sive kind of work d                    | one 16b                                | . Kind of Busines           |                                                    |
| hours<br>"natu                                                                                                                                                                                                                                                                                                                                              |                 | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)         | uring most of working life. DO                              | NOT use retired)                       |                                        |                             |                                                    |
| 36<br>thin 72<br>te.<br>than                                                                                                                                                                                                                                                                                                                                | Completed       |                                                                                                                           | Carpenter                                                   |                                        |                                        | Constr                      | uction                                             |
| 5-0(<br>led wi<br>Hygier<br>other                                                                                                                                                                                                                                                                                                                           |                 | 17. Father's Name (First, Middle, Last)                                                                                   |                                                             | other's Name (First                    |                                        |                             |                                                    |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with th Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a injury or other traumatic event, the Medical Examiner must be noted                                                                          | B B             | Walter Larry Roland  19a. Informant's Name/Relationship (Type, Print )  19b.                                              | Mailing Address (Street and                                 | rlotte  <br>Number or Rural            | nton_l-<br>Route Number,               | City or Town, S             | tate, Zip Code)                                    |
| MD 2<br>d 2 should<br>th and M<br>n 27 is m<br>numatic                                                                                                                                                                                                                                                                                                      | 티               | Charlotte Roland/Mother 119                                                                                               | 933 Montgomery                                              | Lane. W                                |                                        |                             | 00000                                              |
| e, M<br>and 2<br>Health<br>item 2                                                                                                                                                                                                                                                                                                                           | 1               | 20a. Method of Disposition                                                                                                | Disposition (Name of cemeter<br>ry or other place)          | ry, Dat                                | e 20                                   | c. Location - City          | y or Town, State                                   |
| nord                                                                                                                                                                                                                                                                                                                                                        |                 | 1 Burial 2 X Cremation 3 Removal from State                                                                               | Crematory                                                   | Feb.2                                  | 5. 2008                                | Waldor:                     | f, Maryland                                        |
| Baltimore,<br>eemit Pages I a<br>Department of He<br>Important: If ite                                                                                                                                                                                                                                                                                      | 1               | 21. Signature of Funeral Service Licensee                                                                                 | 22. Name and Address of F.                                  |                                        |                                        |                             |                                                    |
| m gale                                                                                                                                                                                                                                                                                                                                                      |                 | 23a. Part I. Enter the disease, or complications that caused the death. Do not                                            | 3035 01d Wash                                               | <u>ington R</u><br>n as cardiac or res | d. Walcory arrest,                     | orf, MD<br>shock, or heart  | Approximate interval                               |
| Physician                                                                                                                                                                                                                                                                                                                                                   |                 | failure. List only one cause on each line.                                                                                |                                                             |                                        |                                        |                             | Between Onset and<br>Death                         |
| aminer                                                                                                                                                                                                                                                                                                                                                      |                 | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):                         | 6                                                           |                                        |                                        |                             |                                                    |
|                                                                                                                                                                                                                                                                                                                                                             |                 | Sequentially list conditions, b. Funtured comebral and                                                                    | irysi.                                                      |                                        |                                        |                             |                                                    |
|                                                                                                                                                                                                                                                                                                                                                             | iner            | if any, leading to immediate cause. Enter Underlying Cause                                                                | -sfr                                                        |                                        |                                        |                             |                                                    |
| - t                                                                                                                                                                                                                                                                                                                                                         | Examine         | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):                        |                                                             |                                        |                                        |                             |                                                    |
| Records, P.O. Box 68760, The law requires that the death certificate be executed rate has been signed by the attending physician and oage 2 should be detached for use as the burial - transit                                                                                                                                                              | <u>_</u>        | M UNPENDED AMENDED 23a,b, Pt II,                                                                                          | 27 per ME ø877 3                                            | 3/18/08 amb                            |                                        |                             |                                                    |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial | Physician/Medic | IF FEMALE: 23c. If yes, outcome of pregnancy                                                                              | , Zi per ill goii s                                         | 5/ 10/ 00 dill                         | - 1                                    | 23d. Date of de             |                                                    |
| Box 68760, e death certificate be the attending physic ed for use as the bur                                                                                                                                                                                                                                                                                | an/N            | 23b. Was decedent pregnant in the nast 12 months?                                                                         | T CLEI GOULT                                                | Ectopic pregnancy                      |                                        | Month                       | Day Year                                           |
| OX 6<br>ath cer<br>attend<br>or use                                                                                                                                                                                                                                                                                                                         | sici            | past 12 months?  4 Pregnant at time of death  Yes 2 No 9 Unknown                                                          | Other (Specify)                                             |                                        |                                        |                             |                                                    |
| ). B<br>the de<br>by the                                                                                                                                                                                                                                                                                                                                    | Phy             | Part II. Other significant conditions contributing to death but not resulting                                             | g in the underlying cause giver                             | n in Part I.                           |                                        |                             | te to the cause of death?                          |
| P.C es that igned be dett                                                                                                                                                                                                                                                                                                                                   | d by            | Chronic drug use                                                                                                          |                                                             |                                        |                                        |                             | Probably 4 Unknown  ere autopsy findings available |
| rds,<br>requir<br>been s                                                                                                                                                                                                                                                                                                                                    | Completed       |                                                                                                                           |                                                             |                                        | 24a. Was an<br>autopsy                 | prie                        | or to completion of cause of ath?                  |
| eco<br>he law<br>ite has                                                                                                                                                                                                                                                                                                                                    | duc             |                                                                                                                           |                                                             | Telegrapes vii                         | perform<br>Yes 2                       |                             | Yes 2 No                                           |
| al R. Then: T                                                                                                                                                                                                                                                                                                                                               | BeC             | 25. Was case referred to medical                                                                                          | I Ott                                                       | Death (Check only                      |                                        | esidence 6                  | Othor: Scane                                       |
| Division of Vital Records, P.O. rater death or Attending Physician: The law requires that the rater death.  The rate death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.                                                                                                               | To B            | 1 Yes 2 No                                                                                                                | outpatient 3 DOA  Time of Injury 28c. Injury a              |                                        |                                        | w injury occurred           |                                                    |
| n of<br>ding P<br>After<br>funers                                                                                                                                                                                                                                                                                                                           |                 | 27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)                                        |                                                             | 2 No                                   |                                        |                             |                                                    |
| Siol<br>Atten<br>r death<br>ector:<br>by the                                                                                                                                                                                                                                                                                                                | cati            | 2 Accident Investigation 28e. Place of Injury - At home, f                                                                | arm, street, factory, office build                          | ding, etc. 28                          | if. Location (Str                      | eet and Number              | or Rural Route Number, City                        |
| Divi<br>talor<br>rs after<br>al Dir                                                                                                                                                                                                                                                                                                                         | Certification:  | Suicide 6 Could not be determined (Specify)                                                                               |                                                             | - 5                                    |                                        |                             |                                                    |
| Hospi<br>24 hou<br>Funer<br>tely fil                                                                                                                                                                                                                                                                                                                        |                 | 20a Certifier Take heat of my knowledge de                                                                                | eath occurred at the time, date                             | and place, and du                      | e to the cause                         | (s) and manner and du       | es stated.<br>e to the cause(s)                    |
| Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,                                                                                                                                                                           | Medical         | one) 2 Medical Examiner: On the basis of examination and/or and manner stated.                                            | 29c. License n                                              |                                        |                                        |                             | d (Month, Day, Year)                               |
| A FARS                                                                                                                                                                                                                                                                                                                                                      | ž               | 29b. Signature and title of certifier                                                                                     | O.C.M.                                                      |                                        |                                        | February 17                 |                                                    |
|                                                                                                                                                                                                                                                                                                                                                             |                 | Father Com- Polled was                                                                                                    |                                                             |                                        |                                        |                             |                                                    |
|                                                                                                                                                                                                                                                                                                                                                             |                 | 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Exar | miner 111 Penn Stre                                         | et, Baltimore,                         | MD 21201                               |                             |                                                    |
| S                                                                                                                                                                                                                                                                                                                                                           | tat             | 31. Date filed (Month, Day Year) 2 1 2008 32. Registrar's Signature                                                       |                                                             |                                        |                                        |                             |                                                    |
| Regis                                                                                                                                                                                                                                                                                                                                                       | stra            | LERS I TONO TOURS TO                                                                                                      | - Marie                                                     |                                        |                                        |                             |                                                    |

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|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------------|----------------------------------------|--------------------------------------------|---------------------------------------|-------------------------|--------------------------------------------------|
| H              | Physicia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | an             | 1. Decedent's Name (First, Middle, E<br>Florence Eli                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                   | 5.d                                      |                                                              |                                        | 2. Date of Dea                             | Day                                   | Yeer                    | 3. Time of Death 5:15 PM                         |
|                | /Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | al -           | 4e. Facility Name (If not institution, g                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                   |                                          | 4b. City, Town, or                                           | Location of Dea                        | Feb.                                       | 12, 2<br>4c. County                   | 2008<br>of Death        |                                                  |
|                | Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | er             | Chester Rive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                   |                                          | Chest                                                        | ertown,                                | MD                                         | Kent                                  | t                       |                                                  |
|                | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | 221-40-2215                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | . Sex 7. Age (                                                    | In yrs. last birthda<br>90 Yrs.          | Months Days                                                  | if Under 24 Hrs<br>Hours Min           |                                            | y, Yee <i>r)</i>                      | Coun                    | ace (State or Foreign<br>try)<br>usend, DE       |
|                | and<br>a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | Usual Residence of Decedent  10a. State 10b. County                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                   | IOc. City, Town or                       | _ocation                                                     |                                        |                                            |                                       | 10                      | 0d. Inside City Limits                           |
|                | a-f eh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | tor            | MD Ker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ıt                                                                | Galer                                    | ıa                                                           |                                        |                                            |                                       |                         | 1 □ Yes 2√2 No                                   |
|                | or 28                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Director       | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                   |                                          | 10f. Zip Code                                                |                                        |                                            | 10g. Citizen of                       |                         | itry?                                            |
|                | 8 23a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | rai            | 14069 August                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ine Herman                                                        | n Highwa                                 | ay 216.                                                      |                                        | Specify Yes or No                          | US.                                   | ce - Americ             |                                                  |
|                | iges 1 and 2 should be filed within 72 hours after death with rine maryland it of Health and Mental Hygiene.  If the m 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Mariical Examiner must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Armed Forces?                                                     |                                          | . Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes ♣️ No | an, Mexican, Pue<br>Specify:           | rto Rican, etc.)                           |                                       | ck, White,<br>fy: Whi   |                                                  |
|                | atural<br>cal E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ted k          | 15. Decedent's                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Education                                                         | 16a. Dec                                 | edent's Usual Occup                                          | pation<br>during most of w             | orkina                                     | 16b. Kind of B                        | lusiness/Ind            | dustry                                           |
|                | in i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Completed      | (Specify only highest<br>Elementary/Secondary (0-12)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | College (1-4or 5+                                                 | life                                     | . DO NOT use retired                                         | d)                                     | y                                          | Domos                                 | + i c / (               | Own Home                                         |
|                | filed wi<br>Hygien<br>other th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 12<br>17. Father's Name (First, Middle, La                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | net)                                                              |                                          | Homemak                                                      |                                        | ame (First, Middle,                        |                                       |                         | JWII HOME                                        |
|                | d be ti<br>ental H<br>ked oti<br>ic ever                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Be             | Wilbur Water                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                   |                                          |                                                              |                                        | el Burge                                   |                                       |                         |                                                  |
|                | should<br>nd Me<br>rmark<br>umatik                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <sup>L</sup>   | 19a. Informant's Name/Relationshi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                   | 19b. Ma                                  | iling Address (Street                                        |                                        |                                            |                                       | , State, Zip            | Code)                                            |
| •              | es 1 and 2 and 10 the |                | Millard F. Ro                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | •                                                                 | 20b. Place of Dis                        | Worton  position (Name of rematory or other place)           |                                        | Cheste                                     | rtown<br>20c. Location                | - City or To            | 21620<br>own, Stelle                             |
|                | Pages<br>ent of<br>nt: If I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                | 1 Donation 5 Other (Special Control of the Control | B □Removal from State ocify)                                      |                                          | Odd Fel                                                      |                                        | 2/16/200                                   | 8 Smy                                 | rna,                    | DE                                               |
|                | permit. Pages<br>Department of h<br>Important: If Ite<br>any injury or of<br>once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                | 21. Signature of Funeral Service Li                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                   | hisof                                    | 22. Name and Addre                                           | S Facility                             |                                            | FUNERA                                | L HO                    |                                                  |
|                | nysician<br>/Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | 23a. Part1. Enter the disease, or c<br>shock, or heart failure. List of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | a. A Z                                                            | he death. Do not of the consequence of): | 1                                                            | such as cardi                          | ac or respiratory a                        | rrest,                                | 4                       | Approximate Interval Batween Onset and Death     |
| 装              | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | niner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                   | consequence of):                         |                                                              |                                        |                                            |                                       |                         |                                                  |
| ,<br>)         | te be executed<br>ysician and<br>e burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | cai Exami      | that initiated events<br>resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CDue to (or as a                                                  | consequence of):                         |                                                              |                                        |                                            |                                       |                         |                                                  |
|                | tificate<br>ig phy<br>as the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                   |                                          |                                                              |                                        |                                            |                                       |                         |                                                  |
| .0.            | The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 6 9 Unknown  | Fetel death                              | 3 □Ectopic pregnand<br>5 □ Other (specify) _                 | у                                      |                                            |                                       | ate of deliv<br>Month   | rery<br>Day Year                                 |
|                | ires that the signed by the detaction                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | by             | Part II. Other significent condition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ns contributing to death bu                                       | t not resulting in th                    | e underlying cause gi                                        | ven in Part I.                         |                                            | tobacco use co<br>Yes 2 ☑No           |                         | the cause of death? bably 4 DUnknown             |
| Vital necolus, | The law require<br>ate has been sin<br>page 2 should t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Completed      | Huport                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ansion                                                            |                                          |                                                              |                                        | 24a. Wa:<br>auto<br>perf<br>1  Yes         | s an 24b<br>opsy<br>formed?<br>2 DNo  | prior to co<br>death?   | opsy findings available<br>ompletion of cause of |
|                | ician: Th<br>certificate<br>rector, pag                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | a              | 25. Was case referred to medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1.                                                                |                                          |                                                              | 26. Place of D                         | Death Check on                             | - 1                                   |                         |                                                  |
|                | ysician:<br>is certific<br>director,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0 8            | examiner?<br>1 ☐ Yes 2 ☑ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Hospital: 1   Inpatier                                            | nt 2 ☐ ER/Outpa                          | tient 3 DOA                                                  | her: 4 Nursing                         | g Home 5 ☐ Res                             |                                       |                         | rfy)                                             |
|                | 유유                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | atlon: T       | 27. Menner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                   | Yeer) 28b. Tim<br>Inju                   | v Wo                                                         | ury at<br>ork?<br>]Yes 2 ☐ No          |                                            | how injury occ                        |                         |                                                  |
|                | To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Certification: | 3 Suicide 6 Could n<br>4 Homicide determi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ned 288. Flace of triple<br>building, etc                         | . (Ѕреспу)                               | street, factory, office                                      |                                        | City or To                                 | own, State)                           |                         | ral Route Number,                                |
|                | Hospit<br>24 hour.<br>Funera<br>tety fille                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Medical C      | 29a. Certifier 1 Certifying (Check only 2 Medical E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Physician: To the best of xaminer: On the basis of and manner sta | examination and/o                        | eath occurred at the trinvestigation, in my                  | time, date and pla<br>opinion, death o | ace, and due to the<br>courred at the time | e cause(s) and o<br>e, date and place | manner as<br>e, and due | stated.<br>to the cause(s)                       |
|                | o the<br>o the<br>omple                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Med            | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | All                           |                                          |                                                              | nse number                             |                                            | 29d. Date sign                        | ned (Month              | o, Day, Year)                                    |
|                | H 3 F 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | Kurs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Mon                                                               | M                                        |                                                              | 3885                                   | 24                                         | 21                                    | 1410                    | 38                                               |
|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | 30. Name an address of person                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   |                                          |                                                              |                                        |                                            |                                       |                         |                                                  |
|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | , 119 C. N                                                        | North Ma                                 | in Stree                                                     | et, Ga                                 | lena, Mi                                   | D 2163                                | 5                       |                                                  |
| 1              | St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ate            | 31. Date filed (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 32. Registra                                                      | ir's Signature                           | n And                                                        |                                        |                                            |                                       |                         |                                                  |

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9,2008 February 3:12A M Mary Louise Rosier /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7490 Joseph Rosier Place La Plata Charles 8. Date of Birth (Month, Day, Year) July 27,1913 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 214-36-3715 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits MD Charles 1 ☐ Yes 2 No La Plata Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or dical Examiner must be 7490 Joseph Rosier Place 20646 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: **Black** 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed what and Mental Hygien 7 Is marked other the Homemaker Home or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other transmit Daniel Cole Annie Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Newman/Daughter 109 Bertha Circle, Indian Head, MD 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery2/14/2008 La Plata, Maryland 21. Signature of Funeral Service Licensee M00945 22 Name and Address of Eacility AREHART-ECHOLS FUNERAL HOME.P.A. 211 St. Mary's Ave. La Plata, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one c.a. e on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** cusa /Medical Due to (or as a consequence of): Examiner SUTENSOUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 in the past 12 months? 1 ☐ Yes 2 No Month Year Day signed by the al 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1☐ Yes 2 ANo certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

certificate be executed P.O. Box 68760. Division or Vital Records. or Attending Physician: To the Hospital or Attenum; within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur

Baltimore, Maryland 21215-0036

within 72

State Registrar

31. Date filed (Month, Day, Year)

N

30. Name and address of pers

20

29b. Signature and title of certifier

4 | Homicide

29a. Certifier

Medical

TRIFEW 32. Registrar's Signature

opmpleted cause of death (Item 23a) (Type, Print

2 Medical Examiner: On the basis of examiner stated.

W

2008

porte

CV. OV.

Lessel of the cause (s) and manner as stated.

29c. License number

the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

2008

|                                                                                                                              |                                                                                                                                 |               | For<br>State<br>Registrar                                                                                    | State                                   | of Marylan                                       |                                  | artment of F                                |                                    | d Mental Hy                                 | giene<br>Reg. No. 2 | 008                              | 06                                 | 050            |
|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------|----------------------------------|---------------------------------------------|------------------------------------|---------------------------------------------|---------------------|----------------------------------|------------------------------------|----------------|
|                                                                                                                              | Physici                                                                                                                         | an            | 1. Decedent's Name (First, Middle                                                                            |                                         |                                                  |                                  |                                             |                                    | 2. Date of De<br>Month                      | eath<br>Day         | Year                             | 3. Time of                         |                |
|                                                                                                                              | /Medic                                                                                                                          | As I          | Sylvia Rubenst  4a. Facility Name (If not institution                                                        |                                         | mber)                                            |                                  | 4b. City, Town, or                          | Location of De                     | Februar<br>eath                             | 20 8 20 4c. County  |                                  | 8:15                               | A <sup>M</sup> |
| . B                                                                                                                          |                                                                                                                                 |               | Cresthaven Gro                                                                                               |                                         |                                                  |                                  | Silver                                      |                                    |                                             | Monte               |                                  |                                    |                |
|                                                                                                                              | uneral<br>irector                                                                                                               |               | 5. Social Security Number                                                                                    | 6. Sex<br>1 ☐ M 2 🖾 F                   | 7. Age (In yrs. 89                               | last birthday)<br>Yrs.           | If Under 1 Year<br>Months Days              | If Under 24 H<br>Hours M           | lin. 8. Date of Bir<br>(Month, Da<br>July 3 | v. Year)            | 9. Birthp<br>Cour                | olace (State or<br>otry)<br>Jersey | r Foreign      |
| -                                                                                                                            | of the or                                                                                                                       |               | 138-07-0201<br>Usual Residence of Decedent                                                                   |                                         |                                                  |                                  |                                             |                                    | July J                                      | , 1710              |                                  |                                    |                |
| of 1212-0500<br>filed within 72 hours after death with the Maryland<br>Hydiana                                               | ten grafts are more of the management of them 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | 'n            | 10a. State 10b. County                                                                                       |                                         |                                                  | y, Town or Lo                    |                                             |                                    |                                             |                     | 1                                | 0d. Inside Cit  1 X Yes            |                |
| the M                                                                                                                        | 28a-f                                                                                                                           | Director      | MD Montgo                                                                                                    | omery                                   | Gai                                              | therst                           | 10f. Zip Code                               |                                    |                                             | 10g. Citizen of     | What Cour                        | -                                  |                |
| h with                                                                                                                       | 23a or<br>st be                                                                                                                 | al Di         | 248 Hart Mews                                                                                                |                                         |                                                  |                                  | 20878                                       |                                    |                                             | U.S.A.              |                                  | ,                                  |                |
| r deat                                                                                                                       | er mu                                                                                                                           | Funeral       | 11. Marital Status                                                                                           | 12. Was Dec                             | edent Ever in U.<br>orces?                       | .S. 13.\                         |                                             | ispanic Origin?<br>an, Mexican, Pu | (Specify Yes or No<br>uerto Rican, etc.)    | - 14. Ra            | ce - Americ                      |                                    |                |
| rs afte                                                                                                                      | l', or li<br>xamin                                                                                                              | by Fi         | 1 ☐ Never Married 2 ☐ Marr<br>3 ☑ Widowed 4 ☐ Divorced                                                       | If Ves G                                | ve                                               |                                  | I□Yes 2⊠No                                  | Specify:                           |                                             |                     | y. Whit                          |                                    |                |
| 2 hou                                                                                                                        | atura<br>ical Ex                                                                                                                |               | 15. Deceden                                                                                                  | t's Education                           |                                                  | 16a. Deced                       | lent's Usual Occup                          | ation                              |                                             | 16b. Kind of B      |                                  |                                    |                |
| ithin 7                                                                                                                      | Medi                                                                                                                            | Completed     | Elementary/Secondary (0-12)                                                                                  | st grade completed) College (           |                                                  |                                  | kind of work done of NOT use retired        | during most of (                   | working                                     |                     |                                  |                                    |                |
| iled w                                                                                                                       | nt, the                                                                                                                         |               | 12<br>17. Father's Name ( <i>First, Middle,</i>                                                              | I set)                                  |                                                  | Home                             | maker                                       | 18 Mother's I                      | Name (First, Middle                         | Own Ho              |                                  |                                    |                |
| d be fental b                                                                                                                | 27 Is marked other than<br>r traumatic event, the N                                                                             | To Be         | Morris Schindle                                                                                              |                                         |                                                  |                                  |                                             |                                    | Kornbluth                                   |                     | ne)                              |                                    |                |
| 2 should be                                                                                                                  | s marl<br>umati                                                                                                                 | F             | 19a. Informant's Name/Relations                                                                              |                                         |                                                  | 19b. Mailir                      | g Address (Street                           | <del>_</del>                       | Rural Route Numb                            |                     | , State, Zip                     | Code)                              |                |
| and 2                                                                                                                        | n 27 l<br>ner tra                                                                                                               |               | Marcy B. Grace                                                                                               | - Daught                                |                                                  |                                  | art Mews                                    |                                    | ersburg,                                    |                     |                                  |                                    |                |
| Pages 1                                                                                                                      | If iter<br>or oth                                                                                                               |               | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation                                                          | 3 DaRemoval from                        | State 20b. F                                     | Place of Dispo<br>cemetery, crer | sition (Name of natory or other plac        | e)                                 | Date                                        | 20c. Location       | - City or To                     | own, State                         |                |
| it. Pa                                                                                                                       | ortant:<br>njury                                                                                                                |               | 4 □ Donation 5 □ Other (S                                                                                    |                                         | Mt.                                              | . Moria                          | th<br>. Name and Addre                      |                                    | 1/2008                                      | Fairvie             | w, Ne                            | w Jers                             | sey            |
| perm perm                                                                                                                    | Important: If item 27 Is any injury or other train                                                                              |               | Donald (                                                                                                     | Ota                                     | ttem                                             | Da                               | nzansky-(                                   | Goldber                            | g Memoria<br>ke Rockv                       |                     |                                  |                                    |                |
| ш                                                                                                                            | - g III                                                                                                                         |               | 23a. Part1. Enter the disease, or shock, or heart failure. List                                              | complications that                      | caused the seat                                  |                                  |                                             |                                    |                                             |                     | 1 200                            | Approximate<br>Interval Bety       | yeen           |
|                                                                                                                              | sician                                                                                                                          |               | Immediate Cause (Final disease or condition                                                                  | -                                       | brovascı                                         | ılar ad                          | cident                                      |                                    |                                             |                     |                                  | Onset and D                        | eath           |
|                                                                                                                              | ledical<br>aminer                                                                                                               |               | resulting in death)                                                                                          | Due to                                  | (or as a conseq                                  | uence of):                       |                                             |                                    |                                             |                     |                                  |                                    |                |
|                                                                                                                              | 221                                                                                                                             | e             | Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury | b. — Due to                             | (or as a conseq                                  | uence of):                       |                                             |                                    |                                             |                     | -                                |                                    |                |
| cuted                                                                                                                        | nd<br>ransit                                                                                                                    | Examiner      | triat iriitiateu events                                                                                      | с                                       |                                                  |                                  |                                             |                                    |                                             |                     |                                  |                                    |                |
| Se exe                                                                                                                       | ohysician and<br>the burial-transit                                                                                             |               | resulting in death) Last                                                                                     | Due to                                  | (or as a conseq                                  | uence of):                       |                                             |                                    |                                             |                     |                                  |                                    |                |
| icate                                                                                                                        | physics<br>the t                                                                                                                | dical         |                                                                                                              | d                                       |                                                  |                                  |                                             |                                    |                                             |                     |                                  |                                    |                |
| Centif                                                                                                                       | attending p<br>for use as t                                                                                                     | Physician/Med | IF FEMALE:<br>23b. Was decedent pregnant                                                                     |                                         | tcome pf pregna                                  |                                  | 3                                           |                                    |                                             | 23d. Da             | ate of delive                    | ery                                |                |
| death                                                                                                                        | ne atte                                                                                                                         | sicia         | in the past 12 months?<br>1 ☐ Yes 2 🖾 No                                                                     |                                         | birth 2 ☐ Feta<br>nant at time of d              |                                  | Ectopic pregnancy<br>Other <i>(specify)</i> |                                    |                                             | M                   | onth                             | Day Y                              | 'ear           |
| at the                                                                                                                       | signed by the a                                                                                                                 | Phy           | 9 ☐ Unknown  Part II. Other significant conditi                                                              |                                         |                                                  | ulting in the u                  | adorbing aguas abs                          | on in Dort I                       | 220 Did t                                   | tobacco use con     | tribute to t                     | ha agusa af d                      | a a th O       |
| uires t                                                                                                                      | signe<br>d be d                                                                                                                 | d by          | Dementia                                                                                                     | ons continuing to c                     | leath but not res                                | ulang in the ul                  | idenying cause giv                          | en in Fait i.                      |                                             | Yes 2⊠ No           |                                  |                                    |                |
| s sed                                                                                                                        | s been signal                                                                                                                   | Completed     |                                                                                                              |                                         |                                                  |                                  |                                             |                                    | 24a. Was                                    | an 24b.             | Were auto                        | psy findings a                     | available      |
| The la                                                                                                                       | ite has                                                                                                                         | omp           |                                                                                                              |                                         |                                                  |                                  |                                             |                                    | — auto<br>perfo<br>1⊟ Yes                   | psy<br>ormed?       | prior to co<br>death?<br>1 ☐ Yes | mpletion of ca<br>2 □ No           | use of         |
| clan:                                                                                                                        | er this certificate has                                                                                                         | Be C          | 25. Was case referred to medica examiner?                                                                    |                                         |                                                  |                                  |                                             |                                    | Death (Check only                           |                     |                                  |                                    |                |
| Physi                                                                                                                        | this c<br>al dire                                                                                                               | 7             | 1 ☐ Yes 2X No                                                                                                |                                         | Inpatient 2                                      | ER/Outpatien                     |                                             | 4 🗆 IVUI SIII                      | g Home 5 ☐ Resi                             |                     |                                  | y)Group                            | home           |
| ding                                                                                                                         | The Line                                                                                                                        | tion:         | 27. Ma⊓ner of Death  1 ☑ Natural 5 ☐ Pendir  2 ☐ Accident investi                                            | iy .                                    | of Injury<br>oth, Day Year)                      | Injury                           | Wor                                         | yat<br>k?<br>Yes 2 ⊟ No            | 28d. Describe                               | how injury occur    | rrea                             |                                    |                |
| Atten                                                                                                                        | ector<br>by the                                                                                                                 | Certification | 2 Accident Investig                                                                                          | not be 28e. Place                       | e of injury - At ho<br>ling, etc. <i>(Specif</i> | ome, farm, str                   | eet, factory, office                        |                                    |                                             | Street and Num      | ber or Rura                      | al Route Num                       | ber,           |
| ital or                                                                                                                      | ral Dir<br>led in                                                                                                               | Cert          | 4 Hiomicide                                                                                                  | Dulic                                   | ing, etc. (Specif                                |                                  |                                             |                                    | City or To                                  | wn, siale)          |                                  |                                    |                |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. | To the Funeral Director: A completely filled in by the fi                                                                       | Medical       |                                                                                                              | ng Physician: To the Examiner: On the I |                                                  |                                  |                                             |                                    |                                             |                     |                                  |                                    | )              |
| Fo the                                                                                                                       | Fo the<br>comple                                                                                                                | Med           | 29b. Signature and title of certifie                                                                         | / .                                     | -                                                |                                  | 29c. Licens                                 | e number                           |                                             | 29d. Date signe     | ed (Month,                       | Day, Year)                         |                |
| ( 0                                                                                                                          |                                                                                                                                 |               | · Neepo                                                                                                      | Rukre                                   |                                                  |                                  | D005                                        | 2075                               |                                             | Februar             | y 8.                             | 2008                               |                |
| 4                                                                                                                            |                                                                                                                                 |               | 30. Name and address of person                                                                               | who completed cau                       | se of death (Item                                | n 23a) (Type,                    |                                             |                                    |                                             |                     | 1 - 9                            |                                    |                |
| V. T                                                                                                                         | < Sta                                                                                                                           | 10            | Deep Kukreti, 31. Date filed (Month, Day, Year)                                                              |                                         | Laure1 Registrar's Signa                         |                                  | rive, Su                                    | ite 223                            | Laurel                                      | MD 207              | 07                               |                                    |                |
|                                                                                                                              | Registr                                                                                                                         |               | FEB 13                                                                                                       | 2008                                    | we to                                            | Spa                              | di)                                         |                                    |                                             |                     |                                  |                                    |                |

|                            |                                                                                                                                                                                                                                                                                                      |                | 1 - State<br>Registrar                                                          | State of Marylan                                         |                        | artment of Hertificate of E                 |                                |                                  | iene (           | 8                 | 06051                                       |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------|----------------------------------------------------------|------------------------|---------------------------------------------|--------------------------------|----------------------------------|------------------|-------------------|---------------------------------------------|
|                            | 7                                                                                                                                                                                                                                                                                                    | 7.7            | Decedent's Name (First, Middle, Last                                            | ")                                                       |                        |                                             |                                | 2. Date of Deat                  | th               |                   | 3. Time of Death                            |
| H                          | Physici                                                                                                                                                                                                                                                                                              |                | Elinor Allen                                                                    | Ridinas                                                  |                        |                                             |                                | Month<br>Februar                 | Day v 14 20      | Year              | 5:28 A <sup>M</sup>                         |
| A                          | /Medic<br>Examin                                                                                                                                                                                                                                                                                     |                | 4a. Facility Name (If not institution, give                                     |                                                          |                        | 4b. City, Town, or                          | Location of Death              | i ebi dai                        | 4c. County       |                   | J.20 A                                      |
|                            |                                                                                                                                                                                                                                                                                                      |                | Homewood Retireme                                                               | ent Center                                               |                        | Wil                                         | liamsport                      | +                                |                  | Wash              | ington                                      |
|                            | Funeral                                                                                                                                                                                                                                                                                              |                | Social Security Number     6. Se                                                |                                                          |                        | If Under 1 Year<br>Months Days              | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, | Year)            |                   | place (State or Foreign                     |
|                            | Director                                                                                                                                                                                                                                                                                             |                | 408-07-7152                                                                     | □M 2XF 92                                                | Yrs.                   |                                             |                                | May 3,                           |                  |                   | nessee                                      |
|                            | and                                                                                                                                                                                                                                                                                                  |                | Usual Residence of Decedent  10a, State 10b, County                             | 10c. Cit                                                 | y, Town or Lo          | cation                                      |                                |                                  |                  | 1                 | Od. Inside City Limits                      |
|                            | daryl<br>f eho                                                                                                                                                                                                                                                                                       | ō              | Maryland Washir                                                                 |                                                          |                        |                                             |                                |                                  |                  |                   | 1 □Yes 2X No                                |
|                            | 28a-                                                                                                                                                                                                                                                                                                 | Director       | 10e. Street and Number                                                          | igion                                                    | па                     | gerstown                                    |                                | 1                                | 0g. Citizen of N | What Cour         | ntrv?                                       |
|                            | 3a or                                                                                                                                                                                                                                                                                                |                | 11111 Lakeside (                                                                | <b>`</b> +                                               |                        |                                             | 1740                           |                                  |                  |                   | ,                                           |
|                            | me 2;                                                                                                                                                                                                                                                                                                | era            | 11. Marital Status                                                              | 12. Was Decedent Ever in U                               |                        | Was Decedent of His                         | spanic Origin? (Spe            | ecify Yes or No-                 |                  | USA<br>e - Americ |                                             |
| 36                         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23e or 28e-f ehow any injury or other traumatic event, I'm Medical Exerciting roust be notified at ODGE. | by Funeral     | 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced                          | Armed Forces? 1 ☐ Yes 2 \ No If Yes, Give Year or Dates: |                        | fYes, specify Cubar<br>1□Yes 2√□No          | Specify:                       | Rican, etc.)                     | Specify          |                   |                                             |
| 21215-0036                 | 2 hou                                                                                                                                                                                                                                                                                                | ed             | 15. Decedent's Edi                                                              | ucation                                                  | 16a, Deced             | ient's Usual Occupa                         | tion                           |                                  | 16b. Kind of B   |                   | ite<br>dustry                               |
| 215                        | nin 72<br>In "nu<br>Me di                                                                                                                                                                                                                                                                            | Completed      | (Specify only highest grad                                                      | de completed)  College (1-4or 5+)                        | (Give                  | kind of work done di<br>DO NOT use retired) | uring most of worki            | ng                               |                  |                   | ,                                           |
| 21                         | d with                                                                                                                                                                                                                                                                                               | mo;            | 12                                                                              | College (1-401 04)                                       |                        | Homema                                      | ker                            |                                  |                  | Home              |                                             |
| 밀                          | al Hy<br>f oth                                                                                                                                                                                                                                                                                       | Be             | 17. Father's Name (First, Middle, Last)                                         |                                                          |                        |                                             | 18. Mother's Name              | (First, Middle, I                | Maiden Suman     |                   |                                             |
| Va                         | Ment<br>Ment<br>Mrked                                                                                                                                                                                                                                                                                | 70             | Leslie Al                                                                       | len                                                      |                        |                                             | Angie                          |                                  |                  |                   |                                             |
| Maryland                   | 12 should be filed within n and Mental Hygiene. 7 is marked other than "raumatic event, to Me.                                                                                                                                                                                                       |                | 19a. Informant's Name/Relationship (T)                                          | ype, Print)                                              | 19b. Mailir            | ng Address (Street a                        | nd Number or Rura              | il Route Number                  | , City or Town,  | State, Zip        | Code)                                       |
|                            | and<br>lealth<br>m 27                                                                                                                                                                                                                                                                                |                | Robert Ridings - S                                                              |                                                          | 8896                   | Successfu                                   | I Way Wal                      |                                  |                  | 217               |                                             |
| Baltimore,                 | ges 1<br>If of H<br>or of                                                                                                                                                                                                                                                                            |                | 20a. Method of Disposition  XXBurial 2 ☐ Cremation 3 ☐ I                        |                                                          | emetery, crer          | sition (Name of<br>natory or other place    | )                              | Date                             | 20c. Location -  | City or To        | own, State                                  |
| Ë                          | t. Pa<br>rtmen<br>rtent:                                                                                                                                                                                                                                                                             |                | 4 □Donation 5 □ Other (Specify,                                                 | 1,00                                                     | 1                      | n Cemeter                                   |                                |                                  | Frederi          | ck, l             | Maryland                                    |
| Ba                         | Depar<br>Impor                                                                                                                                                                                                                                                                                       |                | 21. Signatur of Juneral Service Lens                                            |                                                          |                        | b <b>ซะก</b> ซ ศีปรร<br>5 S. Cono           |                                | •                                | lliamsp          | ort,              | MD 21795                                    |
| ×                          | đ                                                                                                                                                                                                                                                                                                    |                | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of | lications that caused the deat                           | h. Do not ent          | er the mode of dying                        | , such as cardiac o            | or respiratory arre              | est,             |                   | Approximate<br>Interval Between             |
|                            | Physician                                                                                                                                                                                                                                                                                            |                | Immediate Cause (Final disease or condition                                     | . HUZHEL                                                 | MEn                    | 1) EME                                      | NRA                            |                                  |                  | - 4               | Onset and Death                             |
| 407                        | /Medical                                                                                                                                                                                                                                                                                             |                | resulting in death)                                                             | Due to (or as a conseq                                   | uence of):             | 0 1111                                      | <u>/</u>                       |                                  |                  |                   |                                             |
| 7                          | Examiner                                                                                                                                                                                                                                                                                             |                | Sequentially list conditions,                                                   | h                                                        |                        |                                             |                                |                                  |                  |                   |                                             |
|                            | pe tis                                                                                                                                                                                                                                                                                               | lner           | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as a conseq                                   | uence of):             |                                             |                                |                                  |                  |                   |                                             |
| _                          | cate be executed<br>physician and<br>the burial-transit                                                                                                                                                                                                                                              | Examin         | that initiated events<br>resulting in death) Last                               | c. Due to (or as a conseq                                | uence of):             |                                             |                                |                                  |                  | -                 |                                             |
| 58760,                     | be e<br>sician<br>buria                                                                                                                                                                                                                                                                              | <u>B</u>       |                                                                                 |                                                          |                        |                                             |                                |                                  |                  |                   |                                             |
| 687                        | ficate<br>physis the                                                                                                                                                                                                                                                                                 | edical         |                                                                                 | d                                                        |                        |                                             |                                |                                  |                  |                   |                                             |
| Box                        | es that the death certificate be executed igned by the attending physician and be delached for use as the burial-transit                                                                                                                                                                             | Physician/M    | IF FEMALE:<br>23b. Was decedent pregnant                                        | 23c. If yes, outcome of pregna                           |                        |                                             |                                |                                  | 23d. Da          | ite of delive     | ery                                         |
| m̈.                        | death<br>e atte                                                                                                                                                                                                                                                                                      | cla            | in the past 12 months?                                                          | 1 ☐Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of d      |                        | Ectopic pregnancy Other (specify)           |                                |                                  |                  | onth              | Day Year                                    |
| P.O.                       | t the<br>by th<br>tache                                                                                                                                                                                                                                                                              | hys            | 9 Unknown                                                                       | 9□ Unknown                                               |                        |                                             |                                |                                  |                  |                   |                                             |
|                            | gned<br>gned<br>se de                                                                                                                                                                                                                                                                                | by P           | Part II. Other significant conditions co                                        | ntributing to death but not Tes                          | ulting in the u        | nderlying cause give                        | n in Part I.                   | 23e. Did toi                     | bacco use con    | ribute to th      | he cause of death?                          |
| ord                        | w require<br>been signature                                                                                                                                                                                                                                                                          | ed             | HUPENTER                                                                        | usion [                                                  | JE ENE                 | JSUN                                        |                                | 1 🗆 Ye                           | es 2□No          | 3 Prob            | pably 4 Minknown                            |
| ecc                        | law ri<br>as be                                                                                                                                                                                                                                                                                      | Completed      |                                                                                 |                                                          |                        |                                             |                                | 24a. Was a autops                | n 24b.           | Were auto         | psy findings available mpletion of cause of |
| <u> </u>                   | The<br>ate h<br>page                                                                                                                                                                                                                                                                                 | Con            |                                                                                 |                                                          |                        |                                             |                                | perforr                          | med?             | death?            |                                             |
| /ita                       | clan:<br>ertific                                                                                                                                                                                                                                                                                     | Be             | 25. Was case referred to medical examiner?                                      |                                                          |                        |                                             | 26. Place of Death             | Check only on                    | ne)              |                   |                                             |
| of                         | Physic<br>this c                                                                                                                                                                                                                                                                                     | ဥ              | 1 1 165 2 1 100                                                                 |                                                          | ER/Outpatien           |                                             | 4 Nursing Ho                   | me 5 Reside                      |                  |                   | ý)                                          |
| Division of Vital Records, | fing After                                                                                                                                                                                                                                                                                           | <u>o</u>       | 27. Manner of Death 1 □ Natural 5 □ Pending                                     | 28a. Date of Injury<br>(Month, Day Year)                 | 28b. Time of<br>Injury | Work                                        |                                | 28d. Describe ho                 | ow injury occur  | red               |                                             |
| <u></u>                    | ttsnd<br>death<br>ctor: /                                                                                                                                                                                                                                                                            | cat            | 2 Accident Investigation 3 Suicide 6 Could not be                               | 28e. Place of Injury - At he                             | ome farm str           |                                             | 'es 2 □No                      | 28f Location (SI                 | treet and Numl   | her or Pur        | al Route Number,                            |
| <u>≦</u>                   | after<br>after<br>Direct                                                                                                                                                                                                                                                                             | Certification: | 4 Homicide determined                                                           | building, etc. (Specif                                   | y)                     | eet, factory, office                        |                                | City or Town                     |                  | 107 07 11072      | in nodio nambor,                            |
|                            | To the Hospital or Attanding Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be delached for use as                      |                | 29a. Certifier 1 Certifying Phy                                                 | vsician: To the best of my kno                           | wledge, death          | occurred at the time                        | e, date and place,             | and due to the ca                | ause(s) and m    | anner as s        | tated.                                      |
|                            | in 24<br>the Fu<br>the Fu                                                                                                                                                                                                                                                                            | Medical        | (Check only 2 Medical Exam                                                      | iner: On the basis of examina and manner stated.         | ition and/or in        | vestigation, in my op                       | inion, death occurr            | ed at the time, d                | ate and place,   | and due to        | the cause(s)                                |
|                            | To To                                                                                                                                                                                                                                                                                                | Σ              | 29b. Signaring and the of certifier                                             | 1/4                                                      | 1                      | 29c. License                                | gumber                         | 2                                | 9d. Date signe   | d (Month,         | Day, Year)                                  |
|                            |                                                                                                                                                                                                                                                                                                      |                | MAMX                                                                            | menion                                                   | MAC                    | 10                                          | 1)1106                         |                                  | 7/               | 14/2              | oct &                                       |
| 31                         | 4-1                                                                                                                                                                                                                                                                                                  |                | C-7112 1/2 1/12                                                                 | mpleted cause of death (Item                             | n 23a) (Type,          | Print D. A.                                 | - HA                           | (7)/-                            | 11/1/1/          | 1                 | 2/716                                       |
|                            | Sta                                                                                                                                                                                                                                                                                                  |                | 31. Date filed (Month, Day, Year)                                               | 32. Registrar's Signa                                    | Ature                  | ( ( 21/0                                    | - 1/104                        | -n/ anc                          | w ur             | 00                | 1196                                        |
| 1                          | Registr                                                                                                                                                                                                                                                                                              | -              | FEB 1 5 20                                                                      |                                                          | 1 1                    | ash)                                        |                                |                                  |                  |                   |                                             |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Martin Ambrose Rock, Sr. 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MOSPITA BALTIMORE TIMOR E 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 <del>M</del> M 2□ F Months Days Hours Min. 86 189-18-5981 Director May 26, 1921 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County notifled PA Franklin Waynesboro Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with ıral", or items 23a or Examiner must be 6 Mount Vernon Terrace 17268 death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ambrose Martin Rock 2 Minnie Dallas Clem 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Rock son 8915 Tomstown Rd., Waynesboro, PA 17268 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 N Removal from State Ouincy Cemetery 02/18/2008 Quincy, PA 17247 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Signature of Funeral Service 50 S. Broad St., Waynesboro, PA 17268 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ONGESTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner KENAL Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or Examine The law requires that the death certificate be executed to (or as a consequence of): use as the burial-tran Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Tyes 2 No been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Completed by INTRAVASCUL 1 ☐ Yes DA GULATION 24a. Was an s certificate has b lirector, page 2 s VEUMONIA autopsy performed 1□ Yes 2 No or Attending Physician: funeral director,

2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Thpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

(Check only one)

HMANDEEP

Be

To

Medical Certification:

1 Ocertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of

29c. License number 29d. Date signed (Month, Day, Year)

Name and address of son who completed cause of death (Item 23a) (Type, Print) 2401 WBEL

32. Registrar's Signature

08

Baltimore

USA

Black, White, etc.

unknown

Month

Day

White

Birthplace (State or Foreign Country)

PA

10d. Inside City Limits 1 X Yes 2 No

Approximate Interval Between Onset and Death

State Registrar

After

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital

To the

OH-2

JINGH FEB 1 5 2008

State of Maryland / Department of Health and Mental Hygiene

|                                |                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                             |                               |                                                                   |                                                       | Cer                              | tificate of                                        | Death                           |                                                 | Reg. No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | UÖ                                      | UDI                                                   |                            |
|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------|-------------------------------------------------------|----------------------------------|----------------------------------------------------|---------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------------------------|----------------------------|
|                                |                                                                                                                                                                                                                                                                                                   |                     | 1. Decedent's Name (Fir                                                                                                     | rst, Middle, Las              | st)                                                               |                                                       |                                  | -3                                                 |                                 | 2. Date of D                                    | eath                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Voor                                    | 3. Time                                               | of Death                   |
|                                | Physici<br>/Medic                                                                                                                                                                                                                                                                                 |                     | Dorothy May                                                                                                                 | y Riker                       |                                                                   |                                                       |                                  |                                                    |                                 | Feb.                                            | extstyle 	e | 2008                                    | 6:4                                                   | O PM                       |
|                                | Examin                                                                                                                                                                                                                                                                                            | - 11                | 4a. Facility Name (If not                                                                                                   | institution, giv              | e street and nun                                                  | nber)                                                 |                                  |                                                    |                                 | n, or Location of Dea                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ty of Death                             |                                                       |                            |
|                                |                                                                                                                                                                                                                                                                                                   |                     | Golden Liv                                                                                                                  | ing Cer                       | nter                                                              |                                                       |                                  |                                                    | Hager                           |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | hingt                                   |                                                       |                            |
|                                | <sub>c</sub> Funeral<br>Director                                                                                                                                                                                                                                                                  |                     | 5. Social Security Number 234-01-8006                                                                                       |                               | ex<br>□M 2.2XF                                                    | 7. Age ( <i>In yr</i> s.<br>98                        | last birthday)<br>Yrs.           | Months Day                                         |                                 | 4 Hrs. 8. Data of B<br>Min. (Month, I<br>05/13/ | irth<br>1909<br>1909                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 9. Birthp<br>Cour                       | place (State<br>ntry)                                 | e o <i>r Foreign</i><br>WV |
|                                | pu                                                                                                                                                                                                                                                                                                |                     | Usual Residence of Deci                                                                                                     | edent<br>c. County            |                                                                   | 10c. Cit                                              | y, Town or Loc                   | ation                                              |                                 |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         | Od. Inside                                            | City Limits                |
|                                | faryla<br>f sho                                                                                                                                                                                                                                                                                   | 'n                  |                                                                                                                             | Washing                       | gton                                                              |                                                       | agersto                          |                                                    |                                 |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         |                                                       | es 2□No                    |
|                                | with the N<br>or 28a-<br>be notifi                                                                                                                                                                                                                                                                | Direct              | 10e. Street and Number<br>636 Jeffers                                                                                       |                               | eet                                                               |                                                       |                                  | 10f. Zip Code 217                                  | 40                              |                                                 | 10g. Citizen of US                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What Cour                               | ntry?                                                 |                            |
| 20                             | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if Itam 27 is marked other than "netural", or itams 23a or 28a-f show any injury or othar traumatic evant, the Medical Examinat must be notified at once. | by Funeral Director | 11. Marital Status 1 Never Married 3 Widowed 4                                                                              | 2□ Married                    | 12. Was Dece<br>Armed For<br>1 ☐ Yes<br>If Yes, Giv<br>Year or Da | rces?<br>2 ∰ No<br>e                                  |                                  | /as Decedent of<br>Yes, specify Cu<br>□ Yes 2 1 No |                                 | in? (Specify Yes or N<br>Puerto Rican, etc.)    | Bi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ace - Americ<br>ack, White,<br>ify: Wh: | etc.                                                  |                            |
| 9                              | 2 hour                                                                                                                                                                                                                                                                                            | pe<br>g             | 15. 1                                                                                                                       | Decedent's Ed                 | ucation                                                           | 1(85.                                                 | 16a. Deced                       | ent's Usual Occ                                    | upation                         |                                                 | 16b. Kind of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Business/In                             | dustry                                                |                            |
| 1215                           | vithin 73<br>ne.<br>han "ne                                                                                                                                                                                                                                                                       | Completed           | (Specify or<br>Elemantary/Secondary                                                                                         | nly highest gra               | de completed) College (1                                          | -4or 5+)                                              |                                  | ind of work don<br>O NOT use retii<br>Iomemake     |                                 | of working                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Home                                    |                                                       |                            |
| ,<br>D                         | Hygie<br>Hygie<br>ther ti                                                                                                                                                                                                                                                                         | CO                  | 17. Father's Name (First,                                                                                                   | Middle, Last)                 |                                                                   |                                                       | 1                                | Michael                                            | _                               | 's Name (First, Midd                            | le, Maiden Surna                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         |                                                       |                            |
| lan                            | uld be<br>Aental<br>rked o                                                                                                                                                                                                                                                                        | To Be               | Columbus M                                                                                                                  |                               | LaRue                                                             |                                                       | 10                               |                                                    | M                               | artha Ann                                       | a Roeder                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                         |                                                       |                            |
| Baltimore, Maryland 21215-0020 | nd 2 shoralth and N<br>27 is man                                                                                                                                                                                                                                                                  | i i                 | 19a. Informant's Name/F                                                                                                     |                               |                                                                   |                                                       |                                  |                                                    |                                 | or Rural Route Num<br>et, Hager:                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         |                                                       |                            |
| ore,                           | iges 1 ant of Hear if itam or oths                                                                                                                                                                                                                                                                | 118                 | 20a. Method of Disposition                                                                                                  | emation 3 🗆                   |                                                                   | state                                                 |                                  | atory or other p                                   |                                 | Date 02/16/08                                   | 20c. Location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         |                                                       |                            |
| Itin                           | artmer<br>artmer<br>ortant:<br>injury                                                                                                                                                                                                                                                             |                     | 4 ☐ Donation 5 ☐  21. Signature of Funeral                                                                                  |                               |                                                                   | RO                                                    |                                  | Cemeter<br>Name and Add                            | -                               |                                                 | Martir<br>N. Minni                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         |                                                       | l Home                     |
| Ã                              | Depa<br>impo<br>any ii                                                                                                                                                                                                                                                                            | l. lx               | 137                                                                                                                         | - 7/                          |                                                                   | <                                                     | 30                               | 05 N. Po                                           | otomac                          | Street, H                                       | agerstow                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | m, M                                    | 2174                                                  | 4O                         |
|                                |                                                                                                                                                                                                                                                                                                   |                     | 23a. Part1. Enter the dis<br>shock, or heart fail                                                                           | sease, or comure. List only   | plications that ca<br>one cause on e                              | aused the deat<br>ach line.                           | h. Do not ente                   | r the mode of d                                    | ring, such as o                 | ardiac or respiratory                           | arrest,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                         | Approxim<br>Intervel B<br>Onset an                    | ate<br>setween<br>d Death  |
|                                | Physician<br>/Medical                                                                                                                                                                                                                                                                             |                     | Immediate Cause (Final disease or condition                                                                                 | I                             | _                                                                 | Kida                                                  | U                                |                                                    |                                 |                                                 | 54-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | eous                                    |                                                       |                            |
|                                | Examiner                                                                                                                                                                                                                                                                                          | 7                   | resulting in death)                                                                                                         |                               | a                                                                 | Due to (c                                             | or as a conseq                   | usian<br>uence of):<br>187M                        | /4.04                           |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         | 2 4                                                   | eons.                      |
|                                | cuted<br>nd<br>ransit                                                                                                                                                                                                                                                                             | amin                | Sequentially list conditio                                                                                                  | ons.                          | b                                                                 |                                                       | or as a consequ                  |                                                    | 100                             |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <u> </u>                                | 2                                                     | · ·········                |
| ,092                           | es that the death certificate be executed igned by the attending physician and be detached for use as the bunal-transit                                                                                                                                                                           | Medical Examiner    | Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury that initiated events | liaté                         | C                                                                 | Due to (e                                             | r as a consequ                   | ence of):                                          |                                 |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         |                                                       |                            |
| x 68760,                       | ertificate<br>ding phy<br>se as the                                                                                                                                                                                                                                                               | Medi                | resulting in death) Last                                                                                                    | l                             | d                                                                 | D00 10 (0                                             | as a consequ                     |                                                    |                                 |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         |                                                       |                            |
| Bo                             | attend<br>for us                                                                                                                                                                                                                                                                                  | cian                |                                                                                                                             |                               |                                                                   |                                                       |                                  |                                                    |                                 |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         |                                                       | 4 44-0                     |
| P.O.                           | the de<br>ay the                                                                                                                                                                                                                                                                                  | Physician           | Part II. Other significant                                                                                                  | conditions o                  | ontributing to de                                                 | ath but not res                                       | ulting in the un                 | derlying cause o                                   | jiven in Part I.                |                                                 | d tobacco usa c<br>□ Yas 2□ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         |                                                       | Unknown                    |
|                                | s that<br>gned b                                                                                                                                                                                                                                                                                  | by P                |                                                                                                                             |                               |                                                                   |                                                       |                                  |                                                    |                                 |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         |                                                       |                            |
| Records,                       | requir<br>been s<br>should                                                                                                                                                                                                                                                                        | Completed }         |                                                                                                                             |                               |                                                                   |                                                       |                                  |                                                    |                                 |                                                 | is an autopsy<br>formed?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | av                                      | ere autops<br>railable prid<br>impletion of<br>death? | or to                      |
| Be                             | 0 - 5 1                                                                                                                                                                                                                                                                                           | mo:                 |                                                                                                                             |                               |                                                                   |                                                       |                                  |                                                    |                                 | 10                                              | Yes 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11                                      | ⊐Yes aॄ                                               | <b>√</b> No                |
| ita                            | icien: The<br>certificate<br>rector, pag                                                                                                                                                                                                                                                          | Bec                 | 25. Was case referred to examiner?                                                                                          | medica!                       |                                                                   |                                                       |                                  | - 4                                                | 26. Place                       | of Death (Check onl)                            | one)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         |                                                       |                            |
| Ž                              | Physicien:<br>this certific<br>ral director,                                                                                                                                                                                                                                                      | 2                   | 1 ☐ Yes 25 No                                                                                                               |                               | Hospital: 1 🗆 II                                                  | npatient 2                                            | ER/Outpatient                    | 3□ DOA                                             | -                               | sing Home 5□Re                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         | (y)                                                   |                            |
| ouo                            | Attending PI<br>or death.<br>actor: After the<br>by the funera                                                                                                                                                                                                                                    | atlon:              | 27. Manner of Death  1 Natural 5 [ 2 Accident                                                                               | ☐ Pending investigation       |                                                                   | of Injury<br>h, Day Year)                             | 28b. Time of<br>Injury           | 28c. Inj<br>W                                      | uryat<br>ork?<br>⊒Yes 2∐N       |                                                 | e how injury occ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Derru                                   |                                                       |                            |
| Division of Vital              | 5 # # G                                                                                                                                                                                                                                                                                           | Certification:      |                                                                                                                             | Could not be determined       | ZOE. FIACE                                                        | of Injury - At h<br>ng, etc. <i>(Sp</i> ec <i>i</i> i | ome, farm, stre<br>y)            | et, factory, offic                                 | 9                               | 28f. Location<br>City or T                      | (Street and Nun<br>own, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | nber or Rura                            | al Route N                                            | umber,                     |
|                                | a Hospital<br>24 hours a<br>e Funarel D<br>letely filled                                                                                                                                                                                                                                          | edical C            | 29a. Certifier 12<br>(Check only 2                                                                                          | Cartifying Ph<br>Madical Exan | ysician: To the<br>niner: On the ba<br>and mann                   | sis of examina                                        | wledge, death<br>tion end/or inv | occurred at the<br>estigation, in my               | time, date and<br>opinion, deat | place, and due to the                           | e cause(s) and r<br>e, date and place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | nanner as s<br>, and due t              | tated.<br>o the caus                                  | e(s)                       |
|                                | To tha<br>within 2<br>To the<br>comple                                                                                                                                                                                                                                                            | Me                  | 29b. Signature and title                                                                                                    | of certifier                  |                                                                   | 1                                                     |                                  |                                                    | nse number                      |                                                 | 29d. Date sign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0                                       |                                                       |                            |
|                                |                                                                                                                                                                                                                                                                                                   |                     | Mary                                                                                                                        | Jen                           | 9/1                                                               | iaj                                                   |                                  | 2                                                  | 2836                            | 7_                                              | 2-1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 3-08                                    |                                                       |                            |
| 5                              | H-2                                                                                                                                                                                                                                                                                               |                     | 30. Name and address of Aw 2                                                                                                | person who                    | completed caus                                                    | e of death (Iter                                      | n 23a) (Type, I                  | Print)                                             | Street                          | J-<br>1- Hegi                                   | instern                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | MA                                      | 121                                                   | 740                        |
|                                | Sta<br>Registr                                                                                                                                                                                                                                                                                    | -5.                 | 31. Date filed (Month, Da                                                                                                   | ay, Year)                     | N8 32.                                                            | gistrar's Signa                                       | ature                            | artis                                              |                                 |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         |                                                       |                            |

08-01067 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Doris Russo 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Deat Physician/ 1306 hrs Doris A. Russo Medical Examiner February 6, 2008 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Takoma Park Washington Adventist Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Maryland Months Days Min. Hours Oct.19,1931 Director 220-28-5278 M 2XF 76 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location any Prince George's Adelphi 1 Yes 2 XNo Mərylənd 28a-f show hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Numbe 20783 United States 2706 Rambler Place 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes White Yes 2 No specify: 4 X Divorced Widowed f Yes, Give Year Specify: \$ 6b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. ant: If item 27 is marked other than "na or other traumatic event, the Medical Ex. National Institute Elementary/Secondary (0-12) College (1-4 or 5+) Editor Baltimore, MD 21215-0036 for Health 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Elizabeth A. Ridgeway Wilfred P. McConoughey Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 825 Rowen Road Silver Spring, Maryland 20910 Douglas A. Russo -son 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Ft. 2/9/2008 Department o Lincoln Cemetery Brentwood, Maryland Donation 5 Other Specify 21. Signature of Funeral Service Licenses Bonard Avess Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part I. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Complications Of Abdominal Aortic Aneurysm Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Universiting Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed attending physician and for use as the burial - trai Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 ✔ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Hospital: 4 2 CER/Outpatient 3 DOA Nursing Home 5 Residence 6 Inpatient 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural Yes 2 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) February 7, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner

State Registrar

32. Registrar's Signature 2008 Beller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 8876 2-27-08 vt.
State of Maryland Poepartment of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician EDWARD** WILLIAM SHENK III 2:15A FEBRUARY 19 0.8 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3177 EUTAW FOREST DRIVE WALDORF CHARLES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **1** M 2 □ F 203-36-<del>523</del>2 60 DEC.27,1947 PENNSYLVANIA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes XX No Director CHARLES MD WALDORF 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or be 3177 EUTAW FOREST DRIVE ms 23a 20603 S. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items Black, White, etc. Examiner 1 ☐ Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygient Important; if item 27 is marked other than any injury or other traumatic access. the LOGISTICS 5+ DEPT OF THE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDWARD WILLIAM SHENK JR ANNA MAE GEIST 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JANE M. SHENK/WIFE 3177 EUTAW FOREST DR. WALDORF, MD 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23, 2008 | ALEXANDRIA, VA METROPOLITAN CR. 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licenses ory 10 5635 WASHINGTON AVE., LA PLATA, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical conse uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-trar Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death P.0. the 9□Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 NO Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform 1 ☐ Yes 2 ☑ No 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 \sum Nursing Home 20 No 5 Residence 6 □Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Feat 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature

10+1

State Registrar Name and address of person who completed

31. Date filed (Month, Day,

**Physician** /Medical Examiner

permit. Page Department o Important: If any Injury or

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r 28a-f show notified at

"natural", or Items 23a or edical Examiner must be

the Medical

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Funeral Director

Completed by

Be

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MD

with the Maryland

filed within 72 hours after death

certificate be executed sician and burial-trans attending physician for use as the buris signed by the aid be detached for

Examiner Physician/Medical þ Completed

P

Certification:

Medical

23b. Was decedent pregnant

25. Was case referred to medical examiner?

24a. Was an autopsy performer res 2 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

2 No 1 ☐ Yes 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sandhir 48 Tarn Dr. S Terrace

Hospital:

32. Registrar's Signature William.

Frostburg MD 21532

Registrar

Maryland 21215-0036 ages 1 and 2 should be filed wi ent of Health and Mental Hygien It: If item 27 is marked other th y or other traumatic event, the Baltimore, Pages nent of h or Vital Records, P.O. Box 68760,

Be

To the Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State

|                                                                                                                                                                                    |               | 1                | State State Registrar                                                                                  | e of Marylan<br><b>9a Per FH</b>           | d / Depa<br><b>G877</b> | artment of F<br>3/20/08<br>7/incate of J                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | lealth and M<br>Beath             | fental Hy                              | giene<br>Reg. Ng., | 000                       | 00057                                              |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------|--------------------|---------------------------|----------------------------------------------------|--|--|
|                                                                                                                                                                                    |               |                  | Decedent's Name (First, Middle, Last)                                                                  |                                            |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | 2. Date of De                          | ath 💪              | U U O<br>Year             | 8 Three of Death                                   |  |  |
| Phys                                                                                                                                                                               |               | _                | DOROTHEA                                                                                               |                                            |                         | SHANK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                   | Month 02                               | 23                 | 2008                      | 0840 M                                             |  |  |
|                                                                                                                                                                                    | edica<br>mine |                  | 4a. Facility Name (If not institution, give street ar                                                  | d number)                                  |                         | 4b. City, Town, o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | r Location of Death               |                                        | 4c. C              | ounty of Dea              | ith                                                |  |  |
|                                                                                                                                                                                    |               |                  | WMHS-BRADDOCK CAMPUS                                                                                   |                                            |                         | CUMBERLA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                   |                                        |                    | LEGANY                    |                                                    |  |  |
| Funer                                                                                                                                                                              | ral           | 4                | 5. Social Security Number 6. Sex                                                                       | 7. Age (In yrs.                            |                         | If Under 1 Year Months Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | If Under 24 Hrs.<br>Hours Min.    | 8. Date of Bir<br>(Month, Da<br>Apr 9, | th<br>ly, Year)    | 9. Bir                    | thplace (State or Foreign ountry) MD               |  |  |
| Direct                                                                                                                                                                             | or            |                  | 220-10-4315                                                                                            | <sup>('</sup> 88_                          | Yrs.                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | Apr 9,                                 | 1919               |                           | MD                                                 |  |  |
| and w                                                                                                                                                                              | V             | -                | Usual Residence of Decedent  10a. State 10b. County                                                    | 10c. Cit                                   | y, Town or Lo           | ocation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                   |                                        |                    |                           | 10d. Inside City Limits                            |  |  |
| Aaryla<br>f sho<br>ed at                                                                                                                                                           |               | 5                | MD Allegany                                                                                            |                                            | Cun                     | nberland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                   |                                        |                    |                           | 1x Yes 2 No                                        |  |  |
| the tages                                                                                                                                                                          |               | <u> </u>         | 10e Street and Number                                                                                  |                                            |                         | 10f. Zip Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                   |                                        | 10g. Citize        | en of What Co             | ountry?                                            |  |  |
| with<br>3a or<br>t be                                                                                                                                                              |               | 5                | 42 Arch Street                                                                                         |                                            |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 21502                             |                                        |                    | USA                       |                                                    |  |  |
| d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at           |               | runeral Director | 11 Marital Status 12. Was                                                                              | Decedent Ever in U                         | .S. 13.                 | Was Decedent of H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | lispanic Origin? (Sp              | ecify Yes or No                        | )- 14              | Race - Ame                |                                                    |  |  |
| or ite                                                                                                                                                                             |               | 2                | 1 □ Never Married 2 □ Married 1 □                                                                      | ed Forces?<br>Yes 2∑No<br>es, Give         |                         | 1 Yes 2 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Specify:                          | riioan, cio.)                          |                    | Pro nifer                 |                                                    |  |  |
| OURS (Tall'), C                                                                                                                                                                    |               | 5                | 3 X Widowed 4 □ Divorced Yea                                                                           | r or Dates:                                |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                        |                    | W                         | hite                                               |  |  |
| 5-C                                                                                                                                                                                |               | Completed        | 15. Decedent's Education<br>(Specify only highest grade compl                                          | eted)                                      |                         | edent's Usual Occup<br>e kind of work done<br>DO NOT use retire                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | ding                                   | 16b. Kind          | d of Business             | s/Industry                                         |  |  |
| vithin han han han han han han han han han ha                                                                                                                                      |               | Ē                | 12,                                                                                                    | ege (1-4or 5+)                             |                         | emaker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | u)                                |                                        | Owr                | n Home                    | ۵                                                  |  |  |
| Hygie nt, th                                                                                                                                                                       | ď             | 3                | 12 17. Father's Name (First, Middle, Last)                                                             | -                                          | HOHI                    | <u>cilianci</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 18. Mother's Nam                  | e (First, Middle                       |                    |                           | -                                                  |  |  |
| Maryland 21215-0036 to 2 should be filed within 72 hours aff this and Mental Hygiene. Z? is marked other than "natural"; or traumatic event, the Medical Exami                     |               | ו מֿ             | Clovis Russull Cox                                                                                     |                                            |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Agnes                             | МасМи                                  | llan (E            | 3rown)                    | Cox                                                |  |  |
| Taryla 2 should and Men is marke                                                                                                                                                   |               | 2  -             | 19a. Informant's Name/Relationship (Type. Prin                                                         | t)                                         | 19149                   | ing Address (Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | and Number or Rui                 |                                        |                    | Town, State,              | Zip Code)                                          |  |  |
| , Ma<br>and 2 s<br>ealth au<br>n 27 is                                                                                                                                             |               |                  | Bonnie Lockard                                                                                         | daughter                                   | 42                      | Arch Stre                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | et                                | Cun                                    | nberla             | nd l                      | MD 21502                                           |  |  |
| s 1 all Hez                                                                                                                                                                        |               |                  | 20a. Method of Disposition                                                                             | 20b. i                                     | Place of Disp           | osition (Name of<br>ematory or other pla                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ce)                               | Date                                   | 20c. Loca          | ation - City o            | r Town, State                                      |  |  |
| Pages<br>Tent of Int. If its                                                                                                                                                       |               |                  | 1 ☐ Burial 2 ★ remation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)                                   |                                            |                         | ineral Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                   | 2/24/2008                              | Cre                | esapto                    | wn MD                                              |  |  |
| alti<br>mit.<br>partn<br>porta<br>v Inju                                                                                                                                           | ouce.         | Ī                | 21. Signature of Funeral Service License                                                               | (                                          | 2                       | 22. Name and Addre<br>Scarpe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ess of Facility<br>III Funeral Ho | me, PA                                 |                    | -0.5                      |                                                    |  |  |
| m abes                                                                                                                                                                             | ö             | 1                | 11/1/00/11/                                                                                            |                                            |                         | 108 Vir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ginia Avenue:                     | Cumberla                               |                    | 21502                     | A                                                  |  |  |
|                                                                                                                                                                                    | ш             | ŀ                | 28a. Part1. Enter the disease or complications shock, or heart failure. List only one caus             | that caused the deat<br>e on each line.    | th. Do not er           | nter the mode of dyi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ng, such as cardiac               | or respiratory a                       | arrest,            |                           | Approximate<br>Interval Between<br>Onset and Death |  |  |
| Physicia                                                                                                                                                                           | -             | İ                | Immediate Cause (Final disease or conditiona.                                                          | Wrote                                      | 2115                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                        |                    |                           | 20641                                              |  |  |
| /Medic<br>Examin                                                                                                                                                                   | _             |                  | resulting in death)                                                                                    | ue to (or as a cons                        | uence of):              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                        | Onset and Death    |                           |                                                    |  |  |
| LAGIIIII                                                                                                                                                                           | 200           | ١                | Sequentially list conditions, b.                                                                       | ue to (or as a consec                      | mence of):              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                        |                    |                           |                                                    |  |  |
| Vo tist                                                                                                                                                                            |               | E                | if any, leading to immediate cause. Early to John Graph Cause (Disease or injury that initiated events | de to (or as a consec                      | quenoe ory.             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                        |                    |                           |                                                    |  |  |
| xecur<br>and                                                                                                                                                                       |               | Examiner         | that initiated events c                                                                                | ue to (or as a consec                      | uence of):              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                        |                    |                           |                                                    |  |  |
| ecords, P.O. Box 68760,  law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit      |               | dical            | d                                                                                                      |                                            |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                        |                    |                           |                                                    |  |  |
| 68/<br>ificate                                                                                                                                                                     |               | ĕ                |                                                                                                        |                                            |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                        |                    |                           |                                                    |  |  |
| Box<br>eath cert<br>attending<br>for use                                                                                                                                           |               | 2                |                                                                                                        | es, outcome pf pregn<br>Live birth 2 🗆 Fet |                         | □Ectopic pregnanc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | nv                                |                                        | 23                 | 3d. Date of d             |                                                    |  |  |
| cords, P.O. Box 6 w requires that the death certific been signed by the attending p                                                                                                |               | Physician/Me     | in the past 12 months?                                                                                 | Pregnant at time of                        |                         | Other (specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ·y                                |                                        |                    | Month                     | Day Year                                           |  |  |
| P.O.                                                                                                                                                                               |               | hys              | 9 🗆 Unknown                                                                                            |                                            |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | 00 011                                 |                    |                           | 4.41.                                              |  |  |
| S, F es that general services de-                                                                                                                                                  |               | by I             | Part II. Other significant conditions contributing                                                     |                                            | sulting in the          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ven in Part I.                    |                                        |                    | ie contribute<br>]No 3∐ l | to the cause of death?  Probably 4 DUnknown        |  |  |
| equir<br>equir<br>en si                                                                                                                                                            |               | <u>8</u>         | Coroneur a                                                                                             | leng -                                     |                         | and .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                   | '-                                     | ITES ZL            | 1140 201                  | Flobably 4 Tollidiowii                             |  |  |
| law las be                                                                                                                                                                         | ,             | Completed        |                                                                                                        |                                            |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | 24a. Wa                                | opsy               | prior to                  | autopsy findings available completion of cause of  |  |  |
| al Rec                                                                                                                                                                             | n l           | 50               |                                                                                                        |                                            |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | 1□ Yes                                 | formed?<br>2.2 No  | death?<br>1 ☐ Ye          |                                                    |  |  |
| Vital F ician: Th certificate ector, pag                                                                                                                                           |               | Be               | 25. Was case referred to medical examiner?                                                             |                                            |                         | 101                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 26. Place of Dea                  | th Check onl                           | one                |                           |                                                    |  |  |
| or Vita Physician: this certifical director.                                                                                                                                       |               | 2                | 1 Yes 2 No Hospital                                                                                    | 1 mpatient 2                               | ER/Outpatie             | EUR 2 DOW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4 LI Nursing H                    | ome 5 ☐ Res                            |                    |                           | pecify)                                            |  |  |
| Jn (                                                                                                                                                                               |               | <u>ö</u>         | 1 Natural 5 Pending                                                                                    | Date of Injury<br>(Month, Day Year)        | Injury                  | Wo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ork?<br>]Yes 2∐No                 | Zou. Describe                          | , now injury       | occurred                  |                                                    |  |  |
| /ision Attending r death. ector: After                                                                                                                                             |               | icat             | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e                                            | Place of injury - At h                     | ome. farm. s            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | 28f. Location                          | (Street and        | Number or                 | Rural Route Number,                                |  |  |
| Division or Vital Records, to Attending Physician: The law requires tafer death.  Director: After this certificate has been signed in by the funeral director, page 2 should be of |               | Certification:   | 4 ☐ Homicide determined                                                                                | building, etc. (Speci                      | ify)                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | City or To                             | own, State)        |                           |                                                    |  |  |
| Hospital Hospital Funeral Funeral I                                                                                                                                                |               |                  | 29a. Certifier Certifying Physician:                                                                   | To the best of my kn                       | owledge, dea            | ath occurred at the t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ime, date and place               | , and due to th                        | e cause(s)         | and manner                | as stated.                                         |  |  |
| Division or Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.   | i i           | edical           | (Check only 2 Medical Examiner: Or one)                                                                | n the basis of examin<br>d manner stated.  | ation and/or            | investigation, in my                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | opinion, death occu               | irred at the time                      |                    |                           |                                                    |  |  |
| To the I<br>within 2<br>To the I                                                                                                                                                   |               | ž                | 29b. Signature and title of certified                                                                  |                                            |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | se number                         |                                        |                    |                           | nth, Day, Year)                                    |  |  |
| 1                                                                                                                                                                                  |               |                  | home                                                                                                   |                                            |                         | 1)0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 033286                            |                                        | tel                | , 24,                     | 5603                                               |  |  |
| 9                                                                                                                                                                                  |               | Ì                | 30. Name and address of person to complete                                                             | d cause of death (Ite                      | m 23a) (Type            | e, Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0                                 |                                        |                    |                           | 1                                                  |  |  |
|                                                                                                                                                                                    |               |                  | Sunil Gapta M.                                                                                         | D. 725                                     | Ken                     | Do<br>+ Avenu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | e Lumb                            | parlano                                | I, N               | laryl                     | and                                                |  |  |
| 39                                                                                                                                                                                 | Stat          |                  | 31. Date filed (Month, Day, Year) FEB 2 7 200                                                          | 32, Registrar's Sign                       | ature                   | Locals 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                   |                                        |                    | ,                         |                                                    |  |  |
| Reg                                                                                                                                                                                | gistra        | ır               | <b>上京市中(100</b>                                                                                        | 1000000                                    | No.                     | A STATE OF THE PARTY OF THE PAR |                                   |                                        |                    |                           |                                                    |  |  |

DHMH 17 Rev 1/2001

State Registrar

Frederick wol 2/202

of death (Item 23a) (Type, Print)

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------|-------------------------------|----------------------------------|------------------------------|----------------------------------------|----------------------------------|-----------------------------------------------|----------------------------------------------|
| Physic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ian              | Decedent's Name (First, Middle, Last)                                                                                                                      |                                                                             |                             |                               |                                  |                              | 2. Date of Dear<br>Month               | th<br>Day                        | Year                                          | 3. Time of Death                             |
| /Medi<br>Exami                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | cal              | HOWARD B. SPRING  4a. Facility Name (If not institution, give s.                                                                                           |                                                                             |                             | 4b. C                         | itv. Town, or I                  | ocation of Dea               | Februar                                | y 19 2                           | 2008<br>of Death                              | 12:40 P M                                    |
| Exami                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | lei              | Harford Memorial                                                                                                                                           |                                                                             |                             |                               | •                                | Grace                        |                                        | Harfo                            |                                               |                                              |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 217-03-4444                                                                                                                                                | M 2DE                                                                       | n yrs. last birth<br>90 Y   | nday) If Un<br>Mont           |                                  | If Under 24 Hrs<br>Hours Min |                                        | Year)                            | 9. Birthp<br>Coun<br>Dela                     | lace (State or Foreign<br>try)<br>Ware       |
| yland<br>Now                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | Usual Residence of Decedent  10a. State 10b. County                                                                                                        | 1                                                                           | Oc. City, Town              | or Location                   |                                  |                              |                                        |                                  | 1                                             | 0d. Inside City Limits                       |
| e Man                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ctor             | MD Harford                                                                                                                                                 |                                                                             | Dari                        | lingto                        | n                                |                              |                                        |                                  |                                               | 1 ☐ Yes 2 🔀 No                               |
| death with the Maryland<br>me 23a or 28a-f ehow<br>LITMEL be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Funeral Director | 10e. Street and Number                                                                                                                                     |                                                                             |                             | 10f.                          | Zip Code                         |                              | 1                                      | 0g. Citizen of \                 |                                               | try?                                         |
| leath v                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | erai             | 3602 Dublin Road                                                                                                                                           | 2. Was Decedent Eve                                                         | er in U.S.                  | 13. Was De                    | 21034                            | panic Origin? (              | Specify Yes or No-                     |                                  | JSA<br>e - Americ                             | an Indian,                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | b S              | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced                                                                                                     | Armed Forces? 1 ☑ Yes 2 ☐ No If Yes Give                                    | WWII                        |                               | pecify Cuban<br>s 2□XNo          | Mexican, Pue                 | Specify Yes or No-<br>rto Rican, etc.) |                                  | ck, White,                                    |                                              |
| rz I 3-0036 within 72 hours af ne. hen "natural", or Medical Expri                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | eted             | 15. Decedent's Educ<br>(Specify only highest grade                                                                                                         |                                                                             | 16a. I                      | Decedent's U<br>(Give kind of | sual Occupat                     | ion<br>uring most of wo      | orking                                 | 16b. Kind of B                   | usine <i>s</i> s/Ind                          | dustry                                       |
| within she within                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Completed        | Elementary/Secondary (0-12)                                                                                                                                | College (1-4or 5+)                                                          |                             | iite DONO<br>re Fiq           |                                  | •                            |                                        | Civi1                            | Serv                                          | ice                                          |
| Hygie other                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Be Co            | 17. Father's Name (First, Middle, Last)                                                                                                                    |                                                                             | 1.11                        | Le rig                        |                                  | 18. Mother's Na              | me (First, Middle, i                   | Maiden Suman                     | ne)                                           |                                              |
| Mental Hy<br>Inked oth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | To B             | Howard C. Spring                                                                                                                                           | er                                                                          |                             |                               |                                  | Flore                        | nce Carpe                              | nter                             |                                               |                                              |
| Vialing the mand of the mand o |                  | 19a. Informant's Name/Relationship (Type<br>Margaret Springer/                                                                                             |                                                                             |                             | -                             |                                  |                              | dural Route Number<br>lington,         |                                  |                                               | Code)                                        |
| Healther 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  | 20a. Method of Disposition                                                                                                                                 |                                                                             | 20b. Place of               | Disposition (                 | Name of                          |                              |                                        | 20c. Location -                  |                                               | wn, State                                    |
| Pages<br>lent of<br>nt: If If                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 1 Donation 5 Other (Specify)                                                                                                                               | moval from State                                                            | cemetery<br>Dublin          |                               | or other place,<br>metery        |                              | 3/2008                                 | Street                           | , Mar                                         | y1and                                        |
| Dallimor permit. Pages Depertment of Important: if it eny injury or o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | 21. Signature of Funeral Service License                                                                                                                   | 0                                                                           | 17                          |                               | and Address                      | -                            |                                        |                                  |                                               | 1014                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 23a. Parit I. Exter the disease, or complic                                                                                                                | Torel                                                                       | ulse                        |                               |                                  |                              | me, Inc.,                              |                                  | , PA                                          | 17314                                        |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | Inmediate Cause (Final disease or condition resulting in death)                                                                                            | Due to (or as a c                                                           | LM o                        | nan                           |                                  | ibro                         |                                        |                                  |                                               | Interval Between<br>Onset and Death          |
| certificate be executed ading physicien and use as the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | dical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a c                                                           | ·                           |                               |                                  |                              |                                        |                                  |                                               |                                              |
| death certifi<br>death certifi<br>e attending<br>id for use as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Physician/Med    | IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown                                                                         | c. If yes, outcome of<br>1 Live birth 2 [<br>4 Pregnant at tim<br>9 Unknown | Fetal death                 | 3 □Ectopi<br>5 □ Other        | c pregnancy<br>(specify)         |                              |                                        | 1                                | te of delive                                  | ory<br>Day Year                              |
| requires that the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | b                | Part II. Other significant conditions conf                                                                                                                 | ributing to death but r                                                     | not resulting in            | the underlyin                 | g cause giver                    | n in Part I.                 | 23e. Did to                            |                                  |                                               | ne cause of death?<br>ably 4 []Unknown       |
| The la                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Completed        | 1                                                                                                                                                          |                                                                             |                             |                               |                                  |                              | 24a. Was a autops perfori              | med?                             | Were auto<br>prior to co<br>death?<br>1 ☐ Yes | psy lindings available inpletion of cause of |
| stan: Jan: Jan: Jan: Jan: Jan: Jan: Jan: J                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Be C             | 25. Was case referred to medical examiner?                                                                                                                 |                                                                             |                             |                               |                                  | 26. Place of De              | eath (Check only on                    |                                  |                                               |                                              |
| Physic<br>This co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | မ                | 1 ☐ Yes 2 ☑ No                                                                                                                                             | spital: 1 Impatient                                                         |                             |                               |                                  | 4 🗀 14 ûl 3 il 19            | Home 5 Reside                          |                                  |                                               | y)                                           |
| nding I<br>oth.<br>: After<br>e funer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | tion             | 27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation                                                                                       | 28a. Date of Injury<br>(Month, Day Y                                        | ear) 28b. Ti                | ime or<br>jury<br>M           | 28c. Injury<br>Work?             | at<br>?<br>es 2 ∐No          | 28d. Describe he                       | ow injury occur                  | rea                                           |                                              |
| UNISION OF VICE To the Hospital or Attending Physician: within 24 hours after deeth. To the Funerel Director: After this certifical completely filled in by the funeral director,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Certification;   | 3 Suicide 6 Could not be determined                                                                                                                        | 28e. Place of Injury<br>building, etc. (                                    | - At home, fari<br>Specify) | m, street, fac                | tory, office                     |                              | 28f. Location (Si<br>City or Town      |                                  | er or Rura                                    | l Route Number,                              |
| Hospi<br>4 hour<br>Funer<br>ely fille                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | edicai (         | 29a. Certifier 1 Certifying Phys<br>(Check only 2 Medical Examin                                                                                           | er: On the basis of ex                                                      | amination and               | death secun<br>Vor investigat | ed at the time<br>ion, in my opi | date and place               | a and due to the curred at the time, d | ause(s) and mi<br>ate and place. | and due to                                    | o the cause(s)                               |
| o the<br>ithin 2<br>o the complet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Med              | 29b. Signature and title of certifier                                                                                                                      | and manner stated                                                           | 1.                          |                               | 29c. License                     |                              |                                        | 9d. Date signe                   |                                               |                                              |
| F 3 F 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | Winan                                                                                                                                                      | mo                                                                          |                             |                               |                                  | 2609                         |                                        |                                  | 0 0                                           |                                              |
| 15                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 30 Name and address of person who con                                                                                                                      |                                                                             | th (Item 23a) (T            | Type, Print)                  |                                  |                              | avre De                                |                                  |                                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 210              | 31. Date filed (Month, Day, Year)                                                                                                                          | 1ham MD 32. Registrar's                                                     | Signature                   | - Wat                         | nllas                            | 71.                          | wrede                                  | Virale                           | · vu                                          | 21018                                        |
| Sta<br>Regist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | FEB 2                                                                                                                                                      |                                                                             | English                     | A 1                           | Joseph J                         |                              |                                        |                                  |                                               |                                              |

Springer, Howard Byard

OH-27

State 31. Date filed (Month, Day, Year)
Registrar FEB 1.3

AIN

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Air B

shul-Hage term 19 12/740

|            |                                                                                                                                                                                                                                          |                               | 1- State of Mary Registrer                                                                                                                                                                                                |                             | ertificate of                                                    |                                                       | Mental Hy                           |                                     | UÖ                                   | 06061                                  |  |  |
|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------|-------------------------------------|--------------------------------------|----------------------------------------|--|--|
|            |                                                                                                                                                                                                                                          |                               | Decedent's Name (First, Middle, Last)                                                                                                                                                                                     |                             | Timodio or                                                       | Douin                                                 | 2. Date of D                        | Reg. No.                            |                                      | 3. Time of Death                       |  |  |
|            | Physic                                                                                                                                                                                                                                   |                               | Verna Adella Smi                                                                                                                                                                                                          | ith                         |                                                                  |                                                       | Month<br>January                    | Day                                 | Year<br>O Q                          | 7:35 A M                               |  |  |
|            | /Medi<br>Examii                                                                                                                                                                                                                          |                               | 4a. Facility Name (If not institution, give street and number)                                                                                                                                                            | - C11                       | 4b. City, Town, o                                                | r Location of Death                                   |                                     | 4c. County                          |                                      | 1.33                                   |  |  |
|            |                                                                                                                                                                                                                                          |                               | Holy Cross Hospital                                                                                                                                                                                                       |                             | Silver                                                           | Spring                                                |                                     | Mone                                | tgome                                | rv                                     |  |  |
|            | Funeral                                                                                                                                                                                                                                  |                               | 5. Social Security Number 6. Sex 7. Age (In                                                                                                                                                                               | yrs. last birthday          | If Under 1 Year                                                  | If Under 24 Hrs.                                      | 8. Date of Bi                       |                                     |                                      | place (State or Foreign<br>htry)       |  |  |
|            | Director                                                                                                                                                                                                                                 |                               | 218-59-7420 1□M 2XF                                                                                                                                                                                                       | 49 Yrs.                     | Months Days                                                      | Hours Min.                                            | 11/25/                              | 1958                                |                                      | aica, WI                               |  |  |
|            | p >                                                                                                                                                                                                                                      |                               | Usual Residence of Decedent                                                                                                                                                                                               | - City Town and             |                                                                  |                                                       |                                     |                                     |                                      |                                        |  |  |
|            | anyla<br>shov                                                                                                                                                                                                                            | 2                             | 10a. State   10b. County   10   MD   Prince Georges   10                                                                                                                                                                  | c.City,Town or L<br>Beltsvi |                                                                  |                                                       |                                     |                                     | 1                                    | 0d. Inside City Limits  1√□ Yes 2 □ No |  |  |
|            | Ba-f                                                                                                                                                                                                                                     | octo                          |                                                                                                                                                                                                                           | DCTCSVI                     |                                                                  |                                                       |                                     |                                     |                                      |                                        |  |  |
|            | with t                                                                                                                                                                                                                                   | 늘                             | 10e. Street and Number                                                                                                                                                                                                    |                             | 10f. Zip Code                                                    |                                                       |                                     | 10g. Citizen of                     | What Cour                            | ntry?                                  |  |  |
|            | s 23                                                                                                                                                                                                                                     | ral                           | 4409 Romolon St.                                                                                                                                                                                                          |                             | 20705                                                            |                                                       |                                     | USA                                 |                                      |                                        |  |  |
| 36         | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at | Completed by Funeral Director | 11. Marital Status  1. Marital Status  1. Mar Decedent Ever Armed Forces?  1. Mar Decedent Ever Armed Forces?  1. Mas Decedent Ever Armed Forces?  1. Mas Decedent Ever Armed Forces?  1. Mas Decedent Ever Armed Forces? | in U.S. 13.                 | . Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 № No    | lispanic Origin? (S<br>an, Mexican, Puert<br>Specify: | pecify Yes or N<br>o Rican, etc.)   | Bla                                 | ce - Americ<br>ck, White,<br>by: Bla | etc.                                   |  |  |
| 21215-0036 | tural                                                                                                                                                                                                                                    | edt                           | 3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education                                                                                                                                                             | 16a Dec                     | adent's Usual Occur                                              | ation                                                 |                                     | 16b. Kind of B                      |                                      |                                        |  |  |
| 5          | in 72                                                                                                                                                                                                                                    | olet                          | (Specify only highest grade completed)                                                                                                                                                                                    | (Giv                        | edent's Usual Occup<br>e kind of work done<br>DO NOT use retired | during most of wor<br>d)                              | rking                               | 160. Kaid of B                      | usiness/iiic                         | dustry                                 |  |  |
| 12         | iene.                                                                                                                                                                                                                                    | E                             | Elementary/Secondary (0-12) College (1-4or 5+) 2yrs                                                                                                                                                                       |                             | sing Assis                                                       |                                                       |                                     | P                                   | rivat                                | e                                      |  |  |
|            | filed<br>Hygie<br>other<br>ent,                                                                                                                                                                                                          | Be C                          | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                   | , itali                     | Jing moditi                                                      |                                                       | ne (First, Middle                   | a, Maiden Sumar                     | ne)                                  |                                        |  |  |
| lan        | buld be filed with<br>Mental Hygiene<br>arked other tha                                                                                                                                                                                  | To B                          | Sterling B. Smith                                                                                                                                                                                                         |                             |                                                                  | Catheri                                               | ne Euni                             | ce Taylo                            | or                                   |                                        |  |  |
| Maryland   | 2 should and Menial Is marke                                                                                                                                                                                                             | -                             | 19a. Informant's Name/Relationship (Type, Print)                                                                                                                                                                          | 19b. Mai                    | ling Address (Street                                             |                                                       |                                     |                                     |                                      | Code)                                  |  |  |
|            | nd 2<br>with a<br>27 is                                                                                                                                                                                                                  |                               | Curline Brown/ Sister                                                                                                                                                                                                     | 4409                        | Romolon                                                          | St., Bel                                              | tsville                             | . MD 20                             | 705                                  |                                        |  |  |
| <u>5</u>   | f Healifern                                                                                                                                                                                                                              |                               |                                                                                                                                                                                                                           |                             | osition (Name of omatory or other place                          |                                                       | Date                                | 20c. Location                       |                                      | own, State                             |  |  |
| E O        | Page<br>nent o<br>int: If<br>iry or                                                                                                                                                                                                      |                               | 1   Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)                                                                                                                                        | eorge Wa                    | shington                                                         | Cem. Feb                                              | 16,08                               | Adelphi                             | i, Ma                                | ryland                                 |  |  |
| Baltimore, | permit. Pages 1 and 2<br>Department of Heath a<br>Important: If item 27 is<br>any injury or other tra<br>once.                                                                                                                           |                               | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Fune 716 Kennedy St. NW, Washington, DC 20                                                                                   |                             |                                                                  |                                                       |                                     |                                     |                                      |                                        |  |  |
|            | 2000                                                                                                                                                                                                                                     | 1                             | 23a. art1. Enter the disease, or complication, that caused the                                                                                                                                                            |                             |                                                                  |                                                       |                                     | -                                   | JC 21                                | UU11 Approximate                       |  |  |
|            | ACTOR SALE                                                                                                                                                                                                                               |                               | 23a. Part 1. Enter the disease, or confplication that mused the shock, or heart failure. List only one cause on ach line.     Immediate Cause (Final                                                                      |                             |                                                                  |                                                       | , , , , , ,                         |                                     |                                      | Interval Between<br>Onset and Death    |  |  |
| 7          | Physician /Medical                                                                                                                                                                                                                       |                               | disease or condition a. Cardi                                                                                                                                                                                             |                             | ıry Arrest                                                       |                                                       |                                     |                                     |                                      |                                        |  |  |
| т          | Examiner                                                                                                                                                                                                                                 |                               | Due to (or as a co                                                                                                                                                                                                        |                             |                                                                  |                                                       |                                     |                                     |                                      |                                        |  |  |
|            |                                                                                                                                                                                                                                          | er                            | Sequentially list conditions, if any, leading to immediate b. Reflat                                                                                                                                                      | Failure                     | 2                                                                |                                                       |                                     |                                     |                                      |                                        |  |  |
|            | betr<br>I<br>Insit                                                                                                                                                                                                                       | Examiner                      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  Metas                                                                                                        | tatic Ut                    | erine Lei                                                        | Omvocare                                              | oma                                 |                                     |                                      |                                        |  |  |
| _,         | al-tra                                                                                                                                                                                                                                   | xai                           | that initiated events resulting in death) Last c. Due to (or as a co                                                                                                                                                      |                             | erine bei                                                        | Omyosarc                                              | Olla                                |                                     |                                      |                                        |  |  |
| 68760,     | ficate be executed<br>physician and<br>sthe burial-transit                                                                                                                                                                               | Sall                          |                                                                                                                                                                                                                           |                             |                                                                  |                                                       |                                     |                                     |                                      |                                        |  |  |
| .89        | flicati<br>g phy<br>as the                                                                                                                                                                                                               | edical                        | u.                                                                                                                                                                                                                        |                             |                                                                  |                                                       |                                     |                                     |                                      |                                        |  |  |
| O. Box     | The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit                                                                       | Physician/M                   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown                                                    | Fetal death 3               | □Ectopic pregnancy<br>□ Other (specify) _                        | ,                                                     |                                     |                                     | ate of delive                        | ery<br>Day Year                        |  |  |
| ط          | that<br>ned by<br>deta                                                                                                                                                                                                                   |                               | Part II. Other significant conditions contributing to death but no                                                                                                                                                        | ot resulting in the         | underlying cause giv                                             | en in Part I.                                         | 23e. Did                            | tobacco use con                     | tribute to th                        | he cause of death?                     |  |  |
| Records,   | w requires to been signed should be                                                                                                                                                                                                      | ed by                         |                                                                                                                                                                                                                           |                             |                                                                  |                                                       | 1 🗆                                 | Yes 2□No                            | 3 🗌 Prob                             | ably 4x Unknown                        |  |  |
| 00         | w rec                                                                                                                                                                                                                                    | Completed                     |                                                                                                                                                                                                                           |                             |                                                                  |                                                       | 24a. Wa:                            | s an 24b.                           | Were auto                            | psy findings available                 |  |  |
| Re         | iclan: The lar<br>certificate has<br>ector, page 2                                                                                                                                                                                       | mc                            |                                                                                                                                                                                                                           |                             |                                                                  |                                                       | auto<br>perf                        | opsy<br>ormed?                      | prior to cor<br>death?               | mpletion of cause of                   |  |  |
| ta         | <i>™</i>                                                                                                                                                                                                                                 | e<br>C                        | 25. Was case referred to medical                                                                                                                                                                                          |                             |                                                                  | OC Diseased Day                                       |                                     |                                     | 1 🗌 Yes                              | 2 No                                   |  |  |
| of Vital   | Physiclan:<br>this certificated ral director,                                                                                                                                                                                            | o B                           | examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient                                                                                                                                                                          | 2 ER/Outpatie               | ent 3 DOA Oth                                                    | er: 4 D Nursing H                                     |                                     | idence 6 Oth                        | hor (Specif                          | <u> </u>                               |  |  |
|            |                                                                                                                                                                                                                                          | -                             | 27. Manner of Death 28a. Date of Injury                                                                                                                                                                                   | 28b. Time                   |                                                                  |                                                       |                                     | how injury occur                    |                                      | y)                                     |  |  |
| on         | Attending Ir death.                                                                                                                                                                                                                      | tlo                           | 1 ☑ Natural 5 ☐ Pending (Month, Day Ye 2 ☐ Accident investigation                                                                                                                                                         | ar) Injury                  |                                                                  | k?<br>Yes 2 ∐ No                                      |                                     |                                     |                                      |                                        |  |  |
| Division   | Attendir death.                                                                                                                                                                                                                          | ifica                         | 3 Suicide 6 Could not be determined 28e. Place of Injury                                                                                                                                                                  | At home, farm, s            | treet, factory, office                                           |                                                       |                                     | (Street and Numi                    | ber or Rura                          | al Route Number,                       |  |  |
| ā          | afor A<br>safter<br>I Direct<br>d in by                                                                                                                                                                                                  | Certification;                | 4 Homicide determined building, etc. (S                                                                                                                                                                                   | pecity)                     | -                                                                |                                                       | City or 10                          | wn, State)                          |                                      |                                        |  |  |
|            | To the Hospital or Attenwithin 24 hours after deation to the Funeral Director: completely filled in by the                                                                                                                               | Medical C                     | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of m 2 Medicel Examiner: On the basis of examiner stated.                                                                                            | imination and/or in         | th occurred at the tirnvestigation, in my o                      | ne, date and place<br>pinion, death occu              | and due to the<br>arred at the time | cause(s) and m<br>, date and place, | anner as si<br>and due to            | tated. the cause(s)                    |  |  |
|            | To the within 2 To the complet                                                                                                                                                                                                           | Me                            | 29b. Signature and title of certifier                                                                                                                                                                                     |                             | 29c. Licens                                                      | e number                                              |                                     | 29d. Date signe                     | ed (Month,                           | Day, Year)                             |  |  |
|            | - > - 0                                                                                                                                                                                                                                  |                               | Scottha                                                                                                                                                                                                                   |                             | D006                                                             | 4100                                                  |                                     | Februar                             | y 1,                                 | 2008                                   |  |  |
| ,          | 1/1                                                                                                                                                                                                                                      |                               | 30. Name and address of person who completed cause of death                                                                                                                                                               | (Item 23a) (Type            | Print)                                                           |                                                       |                                     |                                     |                                      |                                        |  |  |
| (1         | 49                                                                                                                                                                                                                                       |                               | Dr. Smitha Bhikkaji 1500 F                                                                                                                                                                                                | orest G1                    | en Rd., S                                                        | ilver Sp                                              | ring MD                             | 20910                               |                                      |                                        |  |  |
|            | Sta<br>Regist                                                                                                                                                                                                                            |                               | 31. Date filed (Month, Day, Year) FEB 1 2 2008 32. Registrar's                                                                                                                                                            | Aparle .                    |                                                                  |                                                       |                                     |                                     |                                      |                                        |  |  |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Damien Stevens, Jr. 1- For State Certificate of Death Reg. No Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day January 31, 2008 0015 hrs Medical Examiner Stevens, Jr. Damien 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Bladensburg 5006 57th Avenue Apt. C4 If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or DC If Under 1 Year 7. Age (In yrs. last birthday) 5 Social Security Number 6 Sex Funeral Months Days Hours July 27,1979 CountryWashington Director 578-02-5327 28  $_{1}X_{M}$ Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 X Yes 2 No Hyattsville Prince George's 28a-f show 'natural", or items 23a or 28a-f shov Examiner must be notified at once. Directo 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 7008 24th Ave. 20783 14 Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Armed Forces? Married Yes Specify: Black Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner m Yes 2X No specify: If Yes, Give Year Divorced Widowed ۾ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10th College (1-4 or 5+) Private Cook 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Sherman Boston Neshell Stevens Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Leketa Kittnell-White/Sister 7008 24th Ave. Hyattsville, MD 20783 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2/11/2008 Washington, DC Glenwood Cemetery Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. N.W. Washington, DC 20011 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause on each line. Death /We dical a. Intra-oral gunshot wound Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED UNPENDED Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy Day Year 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. P.O. Part II. Other significant conditions Yes 2 ✓ No 3 Probably 4 Unknown ≦ Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> examiner? Hospital: Residence 6 V Other: Scene Nursina Home 5 DOA Inpatient 2 ER/Outpatient 3 1 ✔ Yes No ٩ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Jan 30, 2008 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject shot self Certification: 2359 hrs Natural Yes 2 V No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide or Town, State) 5006 57th Avenue Apt. C4, Bladensburg, MD Could not be determined (Specify) Multi-Family Apt. Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 31, 2008 O.C.M.E. m 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner 32. Registrar's Signat 31. Date filed (Month, Day, Year) State 2008 Registrar

|            |                                                                                                                                                                                                                                                                                                                                                              |                   | Please '                                                                                                                          | Type or Print in Black                                                                                                              |                                                                             | -                                                                          |                                                   | 00000                                            |  |  |  |  |  |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------|--|--|--|--|--|
|            |                                                                                                                                                                                                                                                                                                                                                              |                   | For<br>State<br>Registrar                                                                                                         | State of Maryland / D                                                                                                               | ene 008 06063                                                               |                                                                            |                                                   |                                                  |  |  |  |  |  |
| H          | Physici                                                                                                                                                                                                                                                                                                                                                      | an                | 1. Decedent's Name (First, Middle, Las                                                                                            | ·                                                                                                                                   |                                                                             | 2. Date of Dea<br>Month                                                    | tth 3. Time of Death                              |                                                  |  |  |  |  |  |
| *          | /Medic                                                                                                                                                                                                                                                                                                                                                       | al                | ELIZABETH  4a. Facility Name (If not institution, give                                                                            | RUTH SWANN                                                                                                                          | 4b. City, Town, or Location                                                 | Februar<br>of Death                                                        |                                                   |                                                  |  |  |  |  |  |
|            | Examir                                                                                                                                                                                                                                                                                                                                                       | er                | BAltimore Wash                                                                                                                    |                                                                                                                                     |                                                                             |                                                                            |                                                   | Rundel                                           |  |  |  |  |  |
|            | Funeral                                                                                                                                                                                                                                                                                                                                                      |                   | 5. Social Security Number 6. Se 118-50-8023                                                                                       | ¬¬-                                                                                                                                 | hday) If Under 1 Year If Under Months Days Hours                            | 24 Hrs. 8. Date of Birt<br>Min. (Month, Day<br>APRIL 4                     | y, Year) Coi                                      | nplace (State or Foreign<br>untry)<br>YLAND      |  |  |  |  |  |
| Le         | Director                                                                                                                                                                                                                                                                                                                                                     |                   | Usual Residence of Decedent                                                                                                       |                                                                                                                                     |                                                                             | Arkil 4                                                                    | 1924 MAN                                          | 10d. Inside City Limits                          |  |  |  |  |  |
|            | within 72 hours after death with the Maryland<br>ene.<br>then "natural", or Items 23a or 28a-f show<br>he Medical Exeminer must be notified at                                                                                                                                                                                                               | o                 | 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No                                            |                                                                                                                                     |                                                                             |                                                                            |                                                   |                                                  |  |  |  |  |  |
|            | r 28a-f                                                                                                                                                                                                                                                                                                                                                      | Director          | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?                                                                |                                                                                                                                     |                                                                             |                                                                            |                                                   |                                                  |  |  |  |  |  |
|            | th with<br>23a ou<br>ist be                                                                                                                                                                                                                                                                                                                                  |                   |                                                                                                                                   |                                                                                                                                     |                                                                             |                                                                            |                                                   |                                                  |  |  |  |  |  |
|            | tems<br>termi                                                                                                                                                                                                                                                                                                                                                | Funeral           | 11. Marital Status                                                                                                                | 12. Was Decedent Ever in U.S.<br>Armed Forces?                                                                                      | 13. Was Decedent of Hispanic Or<br>If Yes, specify Cuban, Mexica            | igin? (Specify Yes or No-<br>n, Puerto Rican, etc.)                        | 14. Race - Ame<br>Black, White                    |                                                  |  |  |  |  |  |
| 336        | iges 1 and 2 should be filed within 72 hours after death with the Maryle At Health and Mental Hygiene. If item 27 is merked other then "natural", or Items 23a or 28a-f should item 27 is merked other then "natural", or Items 23a or 28a-f should item 27 is merked other then "mature" or other traumatic event, the Medical Exeminer must be notified at | þ                 | 1 ☐ Never Married 2 ☐ Married  3 🔀 Widowed 4 ☐ Divorced                                                                           | 1                                                                                                                                   | 1 ☐ Yes 2X No Specify:                                                      |                                                                            | Specify: B                                        | LACK                                             |  |  |  |  |  |
| 21215-0036 | 72 hor                                                                                                                                                                                                                                                                                                                                                       | Completed         | 15. Decedent's Ed<br>(Specify only highest gra                                                                                    |                                                                                                                                     | Decedent's Usual Occupation (Give kind of work done during mos              | st of working                                                              | 16b. Kind of Business/                            | Industry                                         |  |  |  |  |  |
| 121        | 12 should be filed within 'n and Mental Hygiene.' 7 is merked other then "traumatic event, the Mec                                                                                                                                                                                                                                                           | Jdwc              | Elementary/Secondary (0-12)                                                                                                       | College (1-4or 5+)                                                                                                                  | `life. DO NOT use retired)  CAFETERIA WORKER                                |                                                                            | GOVERNMENT                                        |                                                  |  |  |  |  |  |
|            | other<br>Jent, t                                                                                                                                                                                                                                                                                                                                             | Be Co             | 17. Father's Name (First, Middle, Last)                                                                                           |                                                                                                                                     |                                                                             | er's Name (First, Middle,                                                  |                                                   | -                                                |  |  |  |  |  |
| Maryland   | ould be<br>Menta<br>erked<br>atic ev                                                                                                                                                                                                                                                                                                                         | To B              | HERMAN J. BUTLER                                                                                                                  |                                                                                                                                     |                                                                             | ZABETH E. P                                                                |                                                   | CTOR                                             |  |  |  |  |  |
| Mar        | 12 sho<br>h and<br>7 is m<br>traum                                                                                                                                                                                                                                                                                                                           |                   | 19a. Informant's Name/Relationship (7                                                                                             | ,                                                                                                                                   | . Mailing Address (Street and Numb                                          |                                                                            | -                                                 |                                                  |  |  |  |  |  |
| -          | s 1 and 2<br>f Health<br>tem 27 i                                                                                                                                                                                                                                                                                                                            |                   | RUTH A. WELLS/DAT<br>20a. Method of Disposition                                                                                   | 20b. Place of                                                                                                                       | OLD STAGE RD G                                                              | Date Date                                                                  | MARYLAND 2<br>20c. Location - City or             |                                                  |  |  |  |  |  |
| mo         | Page<br>nent o<br>int: If                                                                                                                                                                                                                                                                                                                                    |                   | 1 Reurial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify)  RESURRECTION CEMETERY 2/13/2008 CLINTON, MARYLAND       |                                                                                                                                     |                                                                             |                                                                            |                                                   |                                                  |  |  |  |  |  |
| Baltimore, | permit. Pages 1 an Department of Heal Important; If item 2 any injury or other once.                                                                                                                                                                                                                                                                         |                   | 21. Signature of Fundral Service Acen                                                                                             | e                                                                                                                                   | 22. Name and Address of Facili                                              |                                                                            | NKINS FUNER                                       |                                                  |  |  |  |  |  |
|            | 70 = 40                                                                                                                                                                                                                                                                                                                                                      |                   | 23a. Pail 1. Enter the disease, or comp                                                                                           | plications that caused the death. Do                                                                                                | 7474 LANDOVER                                                               |                                                                            |                                                   | Approximate<br>Interval Between                  |  |  |  |  |  |
|            | Physician                                                                                                                                                                                                                                                                                                                                                    |                   | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition CONOPS The HOMAT FAILure  |                                                                                                                                     |                                                                             |                                                                            |                                                   |                                                  |  |  |  |  |  |
| 4          | /Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                         |                   | resulting in death)                                                                                                               | Due to (or s a consequence                                                                                                          |                                                                             |                                                                            |                                                   |                                                  |  |  |  |  |  |
| h          | Examiner                                                                                                                                                                                                                                                                                                                                                     | <u></u>           | Sequentially list conditions,                                                                                                     | b. Hypertensia                                                                                                                      |                                                                             |                                                                            |                                                   |                                                  |  |  |  |  |  |
|            | ecuted<br>and<br>I-transit                                                                                                                                                                                                                                                                                                                                   | xaminer           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Dementia                                                                                                                            | Dementia                                                                    |                                                                            |                                                   |                                                  |  |  |  |  |  |
| 0,         |                                                                                                                                                                                                                                                                                                                                                              | Ш                 | resulting in death) Last                                                                                                          | Due to (or as a consequence                                                                                                         |                                                                             |                                                                            |                                                   |                                                  |  |  |  |  |  |
| 68760,     | cate by                                                                                                                                                                                                                                                                                                                                                      | dica              |                                                                                                                                   | .d                                                                                                                                  |                                                                             |                                                                            |                                                   |                                                  |  |  |  |  |  |
| Вох        | n certifi<br>inding<br>use as                                                                                                                                                                                                                                                                                                                                | n/Me              | IF FEMALE:<br>23b. Was decedent pregnant                                                                                          | 23c. If yes, outcome pf pregnancy                                                                                                   | ه الماري                                                                    |                                                                            | 23d. Date of del                                  | of delivery                                      |  |  |  |  |  |
|            | w requires that the death certificate be ex<br>been signed by the attending physician<br>should be detached for use as the buria                                                                                                                                                                                                                             | Physician/Medical | in the past 12 months?<br>1 ☐ Yes 2 ☑ No                                                                                          | 1 ☐ Live birth 2 ☐ Fetal death<br>4 ☐ Pregnant at time of death<br>9 ☐ Unknown                                                      | 3 ☐ Ectopic pregnancy<br>5 ☐ Other (specify)                                |                                                                            | Month Day Ye                                      |                                                  |  |  |  |  |  |
| P.0        | that the<br>ed by t<br>detach                                                                                                                                                                                                                                                                                                                                |                   | 9 ☐ Unknown  Part II. Other significant conditions of                                                                             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did to |                                                                             |                                                                            |                                                   |                                                  |  |  |  |  |  |
| Records,   | quires<br>n sign                                                                                                                                                                                                                                                                                                                                             | d by              |                                                                                                                                   |                                                                                                                                     |                                                                             | 1 🗆                                                                        | Yes 2⊠No 3□Pi                                     | robably 4 DUnknown                               |  |  |  |  |  |
| 000        | law rec<br>as bee<br>2 shou                                                                                                                                                                                                                                                                                                                                  | Completed         |                                                                                                                                   |                                                                                                                                     |                                                                             | 24a. Was                                                                   | an 24b. Were at                                   | utopsy findings available completion of cause of |  |  |  |  |  |
| E R        | The<br>ate h<br>page                                                                                                                                                                                                                                                                                                                                         | Com               |                                                                                                                                   |                                                                                                                                     |                                                                             | autopsy prior to completion o performed? death?  1 ☐ Yes ※ No 1 ☐ Yes 2 No |                                                   |                                                  |  |  |  |  |  |
| Vital      | Physician: this certific                                                                                                                                                                                                                                                                                                                                     | Be                | 25. Was case referred to medical examiner?                                                                                        | Hospital:                                                                                                                           | one Source                                                                  | ~ .                                                                        |                                                   |                                                  |  |  |  |  |  |
| o          | g Physer this eral dir                                                                                                                                                                                                                                                                                                                                       | ٦:<br>ا           | 1 ☐ Yes 2 No<br>27. Manner of Death                                                                                               | 28a. Date of Injury 28b.                                                                                                            | idence 6 Other (Spe<br>how injury occurred                                  | ecity)                                                                     |                                                   |                                                  |  |  |  |  |  |
| ion        | Attending r death. ector: After oy the funer                                                                                                                                                                                                                                                                                                                 | atio              | 1 Natural 5 ☐ Pending investigation                                                                                               |                                                                                                                                     | Time of njury at Work?  M 1 ☐ Yes 2 ☐                                       |                                                                            |                                                   |                                                  |  |  |  |  |  |
| Division   | or Atta<br>ifter de<br>Directa<br>in by ti                                                                                                                                                                                                                                                                                                                   | Certification:    | 3 Suicide 6 Could not be<br>4 Homicide determined                                                                                 | 28e. Place of injury - At home, fa<br>building, etc. (Specify)                                                                      | Street and Number or R<br>wn, State)                                        | ural Route Number,                                                         |                                                   |                                                  |  |  |  |  |  |
| ı          | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral                                                                                                                                                                                                                  | cal Ce            | (Check only 2 Medical Exar                                                                                                        | ysician: To the best of my knowledgeniner: On the basis of examination are                                                          | e, death occurred at the time, date and/or investigation, in my opinion, de | and place, and due to the eath occurred at the time.                       | cause(s) and manner a<br>, date and place, and du | s stated.<br>e to the cause(s)                   |  |  |  |  |  |
|            | To the H<br>within 24<br>To the F<br>complete                                                                                                                                                                                                                                                                                                                | Medical           | one)  29b. Signature and title of cortifier                                                                                       | and manner stated.                                                                                                                  | 29c. License number                                                         |                                                                            | 29d. Date signed (Mon                             |                                                  |  |  |  |  |  |
|            | F 3 F 8                                                                                                                                                                                                                                                                                                                                                      |                   | Hem Jan                                                                                                                           |                                                                                                                                     | Do 2741                                                                     | .5                                                                         | Felancia 10 2008                                  |                                                  |  |  |  |  |  |

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glen Burrie Baltimore Washington Medical Center, Dr Henry Francis

31. Date filed (Month, Day, Year)

FEB 13 2008

Beauty Francis

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Earl Shrieves 2008 Leonard Eb Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Regional AKISBUN, HICOMICE Medical Center If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 X M 2 □ F Hours 218-20-2569 79 6/19/1928 Virginia Usual Residence of Decedent 10c. City, Town or Location 10h. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA 330 Tilahman Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 XYes 2 No If Yes, Give Year or Dates: Army 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 10 diesel mechanic/truck driver Koppers, Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Merritt William Shrieves, Sr. Bernice Dix 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda A. Burt/daughter 340 Tilghman Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place Springhill Memory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2/11/08 Hebron, MD Gardens of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final piratory disease or condition resulting in death) as a consequence of) Lumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

þ

Completed

7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglene Important: If Item 27 is marked other that any injury or other traumatic event; the once.

e filed within 72 hours after de la Hygiene.

other than "natural", or item

Baltimore. Maryland 21215-0036

68760

Box

P.O.

Records.

Division or Vital

page 2 should

attending physician and for use as the burial-tran ed by the a certificate has been funeral director, After this

Physician/Medical \$ Completed Be မ Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Scompletely filled in by the Medical

Anemia 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deatl Natural

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide

29a. Certifier

(Check only one)

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

2 ER/Outpatient 3 DOA

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

24a. Was an

1∐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one,

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

ne and address of person who completed cause of death (Item 23a) (Type, Print)

100 E CARROLL St. SAlisbury Md 21801 STEVEN TE)

31. Date filed (Month, Day, Year)

32. Registrar's Signature FEB 12 2008

and manner stated.

Registrar

|                            |                                                                                                                                                                                |                | 1 - For<br>Stata<br>Registrar                                                                                                                                                                                                    | State of Maryland / Department of Health and Mental Hygiene Certificate of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                         |                                                    |                                            |                                                                                                              |                                                 |                                         |  |  |  |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------|--|--|--|
|                            | Physici                                                                                                                                                                        | an             | 1. Decedent's Name (First, Middle, La                                                                                                                                                                                            | *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (                                       | 7                                                  | 2                                          | 2. Date of Deat<br>Month                                                                                     | h<br>Day Yea                                    | 3. Time of Death                        |  |  |  |
|                            | /Medic                                                                                                                                                                         |                | Croch Va                                                                                                                                                                                                                         | ENNON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | JUFI                                    | 12ER                                               |                                            | FE0                                                                                                          | 17, 200                                         | 1/(17 2/14                              |  |  |  |
|                            | Examir                                                                                                                                                                         | ner            | 4a. Facility Name (If not institution, gi                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | 4b. City, Town, or Lo                              | ocation of Death                           | 4                                                                                                            | 4c. County of De                                | ath                                     |  |  |  |
|                            |                                                                                                                                                                                |                | Carrett Couri                                                                                                                                                                                                                    | y WELONIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1 hosp.                                 | oak 4                                              |                                            | 10                                                                                                           | Cano                                            | 1 ETT                                   |  |  |  |
|                            | Funeral                                                                                                                                                                        |                | Social Security Number     6.,                                                                                                                                                                                                   | Sex 7. Age <i>(l</i><br>11 <u>X</u> M 2 ☐ F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | n yrs. last birthday)<br>Yrs.           |                                                    | If Under 24 Hrs. 8<br>Hours Min.           | B. Date of Birth (Month, Day,                                                                                | Year) 9. B                                      | irthplace (State or Foreign<br>Country) |  |  |  |
|                            | Director                                                                                                                                                                       |                | Usual Residence of Decedent                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 115.                                    |                                                    | 30 0                                       | 2/17/20                                                                                                      |                                                 | aryland                                 |  |  |  |
|                            | lend<br>wo                                                                                                                                                                     |                | 10a. State 10b. County                                                                                                                                                                                                           | 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Oc. City, Town or Lo                    | cation                                             |                                            |                                                                                                              |                                                 | 10d. In side City Limits                |  |  |  |
|                            | Man                                                                                                                                                                            | ţō             | Md. Garret                                                                                                                                                                                                                       | t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0akland                                 |                                                    |                                            |                                                                                                              |                                                 | 1 ☐ Yes 2 ☑ No                          |  |  |  |
|                            | 1 28.                                                                                                                                                                          | Director       | 10e. Street and Number                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | 10f. Zip Code                                      |                                            | 10                                                                                                           | Country?                                        |                                         |  |  |  |
|                            | h wit                                                                                                                                                                          |                | 4480 Cranesville                                                                                                                                                                                                                 | Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         | 21550                                              |                                            |                                                                                                              | USA                                             |                                         |  |  |  |
|                            | eep deep                                                                                                                                                                       | Funerai        | 11. Marital Status                                                                                                                                                                                                               | 12. Was Decedent Eve<br>Armed Forces?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         | Was Decedent of Hisp                               | anic Origin? (Speci                        | fy Yes or No-                                                                                                |                                                 | nerican Indian,                         |  |  |  |
| 9                          | or ftu                                                                                                                                                                         | F              | 1 Never Married 2 ☐ Married                                                                                                                                                                                                      | 1 ☐ Yes 2 ☑ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                         | f Yes, specify Cuban,<br>1 ☐ Yes 2 🔀 No            |                                            | can, etc.)                                                                                                   | Black, Wh                                       |                                         |  |  |  |
| 8                          | d within 72 hours after deeth with the Maryland<br>jiene.<br>I than "natural", or itams 23a or 28a-f ahow<br>I'na Medical Eabminer must be motified at                         | d by           | 3 ☐ Widowed 4 ☐ Divorced                                                                                                                                                                                                         | Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                         | 1 1 1 95 2 123 NO                                  | Specify:                                   |                                                                                                              | Specify: W                                      | nite                                    |  |  |  |
| 5                          | natu                                                                                                                                                                           | Completed      | 15. Decedent's E<br>(Specify only highest gr                                                                                                                                                                                     | ducation<br>ade completed)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (Give                                   | dent's Usual Occupation<br>kind of work done dur   |                                            |                                                                                                              | 16b. Kind of Busines                            | s/Industry                              |  |  |  |
| 12                         | within 72<br>ene.<br>than "nal                                                                                                                                                 | g.             | Elementary/Secondary (0-12)                                                                                                                                                                                                      | College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | life. I                                 | DO NOT use retired)                                |                                            |                                                                                                              |                                                 |                                         |  |  |  |
| d 2                        | Hygie<br>other                                                                                                                                                                 | e Co           | none 17. Father's Name (First, Middle, Lasi                                                                                                                                                                                      | •)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | r                                       | none                                               | 8. Mother's Name (/                        | First Middle A                                                                                               | none                                            |                                         |  |  |  |
| an                         | B d ala                                                                                                                                                                        | 00             | Gary Vernon Swei                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                    | _                                          | riisi, middie, iv<br>1ee                                                                                     | valderi Surname)                                |                                         |  |  |  |
| Maryland 21215-0036        | s 1 and 2 should I<br>f Health and Meni<br>fram 27 is market<br>other traumatics                                                                                               | 2              | 19a. Informant's Name/Relationship                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 19b Mailin                              | ng Address (Street and                             |                                            |                                                                                                              | City of Town State                              | Zin Codo)                               |  |  |  |
| Ž                          | alth ar<br>27 is<br>27 is                                                                                                                                                      |                | Gary V. Sweitzer                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | Cranesvill                                         |                                            |                                                                                                              |                                                 |                                         |  |  |  |
| ē,                         | s 1 and 2<br>f Health<br>item 27<br>other tra                                                                                                                                  |                | 20a. Method of Disposition                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20b. Place of Dispo                     | sition (Name of                                    | Dat                                        | ie 2                                                                                                         | 20c. Location - City of                         | or Town, State                          |  |  |  |
| Baltimore,                 | 00                                                                                                                                                                             |                | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | natory or other place)                             | 02/20/                                     |                                                                                                              | Oakland,                                        |                                         |  |  |  |
| 量                          | permit. Pag<br>Depertment<br>Importent: I<br>any injury o                                                                                                                      |                | 21. Signature o Funeral/Service I                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Friend C                                | . Name and Address                                 | 02/20/                                     |                                                                                                              |                                                 |                                         |  |  |  |
| B                          |                                                                                                                                                                                |                | neral ноm<br>kland, Md                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                    |                                            |                                                                                                              |                                                 |                                         |  |  |  |
|                            |                                                                                                                                                                                |                | 23a. Part1. Enter the disease, or con                                                                                                                                                                                            | plications that caused the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                         |                                                    |                                            |                                                                                                              |                                                 | Approximate                             |  |  |  |
|                            | Physician<br>/Medical<br>Examiner                                                                                                                                              |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                    |                                            |                                                                                                              |                                                 |                                         |  |  |  |
|                            |                                                                                                                                                                                |                | disease or condition resulting in death)                                                                                                                                                                                         | a. Due to (or as a co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | onsequence of):                         | - une                                              | penemie                                    | any vag                                                                                                      | and delin                                       | & Sonny                                 |  |  |  |
|                            |                                                                                                                                                                                |                | Conventially list and divisor                                                                                                                                                                                                    | me-to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | und in                                  | remole                                             | ton 10                                     |                                                                                                              |                                                 |                                         |  |  |  |
|                            |                                                                                                                                                                                | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                                                                                                      | Due to (or as a co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | onsequence of):                         | , , , ,                                            | 1                                          |                                                                                                              |                                                 |                                         |  |  |  |
|                            | ecute<br>and<br>-trans                                                                                                                                                         | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                    |                                            |                                                                                                              |                                                 |                                         |  |  |  |
| 8760,                      | cate be executed<br>physicien and<br>the burial-transit                                                                                                                        | E              | Due to (or as a consequence of):                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                    |                                            |                                                                                                              |                                                 |                                         |  |  |  |
| 387                        | physicate<br>physicate                                                                                                                                                         | dical          | •                                                                                                                                                                                                                                | d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         |                                                    |                                            |                                                                                                              |                                                 |                                         |  |  |  |
| 9 x                        | death certific<br>e attending p<br>id for use as                                                                                                                               | Physician/Me   | IF FEMALE:                                                                                                                                                                                                                       | 23c. If yes, outcome of p                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | regnancy                                |                                                    |                                            |                                                                                                              |                                                 |                                         |  |  |  |
| Вох                        | atter<br>1 for u                                                                                                                                                               | ciar           | 23b. Was decedent pregnant in the past 12 months?                                                                                                                                                                                | 1☐Live birth 2☐<br>4☐Pregnant at tim                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Fetal death 3                           | Ectopic pregnancy Other (specify)                  |                                            |                                                                                                              | 23d. Date of d<br>Month                         | 23d. Date of delivery  Month Day Year   |  |  |  |
| o.                         | the c                                                                                                                                                                          | ysi            | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                                                                                                                                                                                                    | 9□ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 | Cition (specify)                                   |                                            |                                                                                                              |                                                 |                                         |  |  |  |
| Ω.                         | The law requires that the de<br>ste hes been signed by the a<br>page 2 should be detached t                                                                                    | by Pi          | Part II. Other significant conditions                                                                                                                                                                                            | contributing to death but n                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ot resulting in the ur                  | nderlying cause given                              | in Part I.                                 | 23e. Did tob                                                                                                 | d tobacco use contribute to the cause of death? |                                         |  |  |  |
| rds                        | auire<br>n sig                                                                                                                                                                 | D<br>D         | placental                                                                                                                                                                                                                        | alrun                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | tien                                    |                                                    |                                            | 1 ☐ Ye                                                                                                       | 1 Yes 2 No 3 Probably 4 Unkno                   |                                         |  |  |  |
| ပ္ပ                        | s been si<br>should t                                                                                                                                                          | jet            |                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                    |                                            | 24a. Was an                                                                                                  | 24h Were                                        | autoney findings available              |  |  |  |
| Re                         | rician: The lav<br>certificete hes<br>rector, page 2                                                                                                                           | Completed      |                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                    |                                            | 24a. Was an autopsy autopsy performed? 24b. Were autopsy findings availa prior to completion of cause death? |                                                 |                                         |  |  |  |
|                            | Lifficet                                                                                                                                                                       | 0              | 25. Was case referred to medical                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                    | 0.00                                       | 1 Yes 2 No 1 Yes 2 No                                                                                        |                                                 |                                         |  |  |  |
| <u> </u>                   | ysici<br>s cer<br>direci                                                                                                                                                       | To B           | examiner?<br>1 ☐ Yes 2 ☑ No                                                                                                                                                                                                      | Hospital:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2 ER/Outpatien                          | Other                                              | 6. Place of Death                          |                                                                                                              | nce 6 ∐Other <i>(Sp</i>                         | an ful                                  |  |  |  |
| 0                          | g Phys<br>er this<br>herel dii                                                                                                                                                 | 2              | 27. Manne of Death                                                                                                                                                                                                               | 28a. Date of Injury<br>(Month, Day Ye                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         | 28c. Injury at<br>Work?                            |                                            |                                                                                                              | w injury occurred                               | өспу)                                   |  |  |  |
| Ö                          | ath.                                                                                                                                                                           | atio           | 1                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ear) Injury                             |                                                    | s 2 □No                                    |                                                                                                              |                                                 |                                         |  |  |  |
| Division of Vital Records, | l or Attanding<br>after death.<br>Diractor: After<br>I in by the funer                                                                                                         | Certification; | 3 ☐ Suicide 6 ☐ Could not be determined                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Location (Str.<br>City or Town,         | Location (Street and Number or Rural Route Number, |                                            |                                                                                                              |                                                 |                                         |  |  |  |
|                            | rs after<br>al Dira<br>ed in by                                                                                                                                                | Ce             | , State)                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                                                    |                                            |                                                                                                              |                                                 |                                         |  |  |  |
|                            | To the Hospital or Attending Physician: The within 24 hours after death.  To the Euneral Director: After this certificate h completely filled in by the funeral director, page | Medicai        | 29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exal                                                                                                                                                                   | nysician: To the best of miner: On the basis of example and manner stated                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | amination and/or inv                    | occurred at the time,<br>restigation, in my opini  | date and place, and<br>ion, death occurred | d due to the car<br>at the time, da                                                                          | use(s) and manner attended                      | as stated.<br>ue to the cause(s)        |  |  |  |
|                            | To t<br>To ti                                                                                                                                                                  | Σ              | 29b. Signature and title of certifier                                                                                                                                                                                            | The state of the s |                                         | d. Date signed (Mor                                | nth, Day, Year)                            |                                                                                                              |                                                 |                                         |  |  |  |
|                            |                                                                                                                                                                                |                | 1/20n/4                                                                                                                                                                                                                          | , / Turs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1/1/                                    | 106                                                | 1801                                       |                                                                                                              | 2/17                                            | 109                                     |  |  |  |
|                            |                                                                                                                                                                                |                | 30, Name and address of person who                                                                                                                                                                                               | completed cause of death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (Item 23a) (Type, I                     | Print)                                             | - 00                                       |                                                                                                              | , , , [                                         | 1-0                                     |  |  |  |
|                            |                                                                                                                                                                                | 1              | KEN K. DUCZ                                                                                                                                                                                                                      | yuski, mo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | , 311/                                  | 479 57, 5                                          | wite 1                                     | oak                                                                                                          | cland . V                                       | LD 21500                                |  |  |  |
|                            | Sta                                                                                                                                                                            |                | 31. Date filed (Month, Day, Year)                                                                                                                                                                                                | 32. Registrar's                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Signature                               |                                                    | )                                          | /                                                                                                            | 1                                               |                                         |  |  |  |
| *                          | Registra                                                                                                                                                                       | ar             | FEB 2 0                                                                                                                                                                                                                          | 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5 B B                                   | and I                                              |                                            |                                                                                                              |                                                 |                                         |  |  |  |

|                   |                                                                                                                                                                                                                                                           |                | For State Registrar                                                                                                                                                                                                  | State of Marylan                                                                      |                                                   | ent of Health and ate of Death                              | ,                                                                                | 200                                        | 8 0606                                                |  |  |  |  |
|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------|--|--|--|--|
|                   |                                                                                                                                                                                                                                                           |                | Decedent's Name (First, Middle, La.                                                                                                                                                                                  | st)                                                                                   | 001111100                                         | ato or boatir                                               | 2. Date of Dea                                                                   | Reg. No. 🕒 U U                             | 3. Time of Death                                      |  |  |  |  |
| П                 | Physici                                                                                                                                                                                                                                                   |                |                                                                                                                                                                                                                      | VALENTINE                                                                             | GANE                                              | SOMERS                                                      | Month<br>FEB                                                                     | Day Year                                   |                                                       |  |  |  |  |
|                   | /Medic<br>Examir                                                                                                                                                                                                                                          |                | 4a. Facility Name (If not institution, give                                                                                                                                                                          |                                                                                       |                                                   | ry, Town, or Location of Dea                                |                                                                                  | 4c. County of Dear                         |                                                       |  |  |  |  |
|                   |                                                                                                                                                                                                                                                           |                | CORSICA                                                                                                                                                                                                              | HILLS CENT                                                                            |                                                   | ENTREVILL                                                   |                                                                                  | GUEEN                                      | ANNES                                                 |  |  |  |  |
|                   | Funeral<br>Director                                                                                                                                                                                                                                       |                | 5. Social Security Number 6. S 3 1 8 4 0 8 72 0 1 Usual Residence of Decedent                                                                                                                                        | BX 7. Age (In yrs.                                                                    | / Yrs. If Un Month                                | der 1 Year If Under 24 Hrs as Days Hours Min                | (Month, Day                                                                      | th<br>y, Year) 9. Bin<br>4 1934 E          | thplace (State or Foreign<br>puntry) LONDON<br>NGLAND |  |  |  |  |
|                   | Moi Moi                                                                                                                                                                                                                                                   |                | 10a. State 10b. County                                                                                                                                                                                               | 10c. Cit                                                                              | ty, Town or Location                              |                                                             |                                                                                  |                                            | 10d. Inside City Limits                               |  |  |  |  |
|                   | Man<br>a-f sh                                                                                                                                                                                                                                             | ţo             | MD KE                                                                                                                                                                                                                | NT                                                                                    | CHESTE                                            | RTOWN                                                       |                                                                                  |                                            | 1 Yes 2 No                                            |  |  |  |  |
|                   | or 28                                                                                                                                                                                                                                                     | Director       | 10e. Street and Number                                                                                                                                                                                               |                                                                                       |                                                   | Zip Code                                                    |                                                                                  | 10g. Citizen of What Co                    | ountry?                                               |  |  |  |  |
|                   | ath w                                                                                                                                                                                                                                                     | rai            | 3 BY FURD                                                                                                                                                                                                            | COURT                                                                                 |                                                   | 21620                                                       |                                                                                  | U.S.                                       |                                                       |  |  |  |  |
|                   | itame<br>itam                                                                                                                                                                                                                                             | Funeral        | 11. Marital Status                                                                                                                                                                                                   | 12. Was Decedent Ever in U<br>Armed Forces?                                           | .S. 13. Was De<br>If Yes, s                       | cedent of Hispanic Origin? (<br>pecify Cuban, Mexican, Puel | Specify Yes or No-<br>rto Rican, etc.)                                           | - 14. Race - Ame<br>Black, Whit            |                                                       |  |  |  |  |
| 36                | irs aft                                                                                                                                                                                                                                                   | by F           | 1 ☐ Never Married 2 ☐ Married<br>3 ☑ Widowed 4 ☐ Divorced                                                                                                                                                            | 1 ☐ Yes 2 ♠ No<br>If Yes, Give<br>Year or Dates:                                      | 1 ☐ Yes                                           | 2 No Specify:                                               |                                                                                  | Specify: U                                 | HITE                                                  |  |  |  |  |
| 21215-0036        | n 72 hours after death with the Marylend<br>"natural", or itema 23a or 28a-f ahow<br>colcal Examinar must be notified at                                                                                                                                  | ted            | 15. Decedent's Ed                                                                                                                                                                                                    | ucation                                                                               | 16a. Decedent's U                                 | sual Decupation                                             |                                                                                  | 16b. Kind of Business                      | /Industry                                             |  |  |  |  |
| 2                 | c * 3                                                                                                                                                                                                                                                     | Completed      | (Specify only highest gra                                                                                                                                                                                            | College (1-4or 5+)                                                                    | life. DO NO                                       | work done during most of wo<br>Tuse retired)                | orking                                                                           | . 1                                        |                                                       |  |  |  |  |
| 21                | be filed within tal Hygiane. Id other than avent, the M                                                                                                                                                                                                   | Con            | 1.2                                                                                                                                                                                                                  |                                                                                       | Hon                                               | EMAKER                                                      |                                                                                  |                                            | 1AKER                                                 |  |  |  |  |
| Maryland          | ntal H<br>ad ott                                                                                                                                                                                                                                          | Be             | 17. Father's Name (First, Middle, Last)                                                                                                                                                                              |                                                                                       |                                                   |                                                             | 4                                                                                | Maiden Sumame)                             |                                                       |  |  |  |  |
| Ë                 | d Me<br>mark<br>matic                                                                                                                                                                                                                                     | ဥ              | NORMAN (                                                                                                                                                                                                             | EORGE GAN                                                                             |                                                   | and (Street and Mumber of B                                 | TAR JOR                                                                          | IE GIBB                                    | Cin Code)                                             |  |  |  |  |
| <u>s</u>          | s 1 and 2 should<br>f Heelth and Mer<br>item 27 is marks<br>other treumatic                                                                                                                                                                               |                | TIMOTHY G.                                                                                                                                                                                                           | SOMERS                                                                                | 2318 FO                                           | Street and Number or A                                      | LITHERVI                                                                         | LLE MD                                     | 2/093                                                 |  |  |  |  |
| ē,                | Hee<br>Hee<br>Itam                                                                                                                                                                                                                                        |                | 20a. Method of Disposition                                                                                                                                                                                           | 20b. F                                                                                | Place of Disposition (I                           | Name of                                                     | Date                                                                             | 20c. Location - City or                    |                                                       |  |  |  |  |
| Ë                 | 0 0                                                                                                                                                                                                                                                       |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify                                                                                                                                                         | Hemoval from State                                                                    |                                                   |                                                             | 8/19/08                                                                          | CHESTER                                    | MD                                                    |  |  |  |  |
| Baltimore         | permit. Peg<br>Department<br>Important: I<br>any injury o                                                                                                                                                                                                 |                | 21. Signature of Funeral Service Licen                                                                                                                                                                               |                                                                                       |                                                   | and Address of Facility                                     | the state of                                                                     | CHESTER                                    | , , , ,                                               |  |  |  |  |
| <u> </u>          | 80.5 5 8                                                                                                                                                                                                                                                  |                | 1 Varin V. We                                                                                                                                                                                                        | 4-9                                                                                   | 205                                               | SCEEN HERUN                                                 | WAY CHE                                                                          | STERTOWN,                                  | MD 2/620                                              |  |  |  |  |
|                   |                                                                                                                                                                                                                                                           |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Approximate |                                                                                       |                                                   |                                                             |                                                                                  |                                            |                                                       |  |  |  |  |
|                   | Physician                                                                                                                                                                                                                                                 |                | Immediate Cause (Final disease or condition                                                                                                                                                                          | a 2057er                                                                              | enceph                                            | alito                                                       |                                                                                  |                                            | Onset and Death                                       |  |  |  |  |
|                   | /Medical<br>Examiner                                                                                                                                                                                                                                      |                | resulting in death)                                                                                                                                                                                                  | Due to (or as a conseq                                                                |                                                   |                                                             |                                                                                  |                                            |                                                       |  |  |  |  |
|                   |                                                                                                                                                                                                                                                           | -              | Sequentially list conditions, If any, leading to minimodiate  b.  Due to (or as a consequence of):                                                                                                                   |                                                                                       |                                                   |                                                             |                                                                                  |                                            |                                                       |  |  |  |  |
|                   | uted<br>d<br>ansit                                                                                                                                                                                                                                        | Examiner       |                                                                                                                                                                                                                      |                                                                                       |                                                   |                                                             |                                                                                  |                                            |                                                       |  |  |  |  |
| o,                | exection and and rial-tra                                                                                                                                                                                                                                 |                |                                                                                                                                                                                                                      |                                                                                       |                                                   |                                                             |                                                                                  |                                            |                                                       |  |  |  |  |
| 8760,             | Attending Physicien: The law requires that the death certificate be executed roteath. The death cardificate has been signed by the attending physicien and sctor. Alth.  y the funeral director, page 2 should be detached for use as the burial-transit. | cal            |                                                                                                                                                                                                                      | d                                                                                     |                                                   |                                                             |                                                                                  |                                            |                                                       |  |  |  |  |
| 39 )              | artifica<br>ing ph<br>e as t                                                                                                                                                                                                                              | Med            | IF FEMALE:                                                                                                                                                                                                           |                                                                                       |                                                   |                                                             |                                                                                  | 50                                         |                                                       |  |  |  |  |
| Box 6             | that the death certif<br>ed by the attending<br>detached for use as                                                                                                                                                                                       | Physician/Med  | 23b. Was decedent pregnant in the past 12 months?                                                                                                                                                                    | 23c. If yes, outcome of pregna<br>1☐Live birth 2☐Feta                                 | il death 3 □Ectopic                               |                                                             |                                                                                  | 23d. Date of de<br>Month                   | livery<br>Day Year                                    |  |  |  |  |
| o<br>O            | he da<br>the a                                                                                                                                                                                                                                            | yslc           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                                                                                                                                                                                        | 4□Pregnant at time of d<br>9□Unknown                                                  | leath 5 Other                                     | (specify)                                                   |                                                                                  | 1000                                       | <b>52,</b>                                            |  |  |  |  |
| P.0               | that the detack                                                                                                                                                                                                                                           | / Ph           | Part II. Other significant conditions of                                                                                                                                                                             | ontributing to death but not res                                                      | ulting in the underlyin                           | g cause given in Part I.                                    | 23e. Did to                                                                      | obacco use contribute to                   | the cause of death?                                   |  |  |  |  |
| Records,          | quires than<br>n signed t<br>uid be det                                                                                                                                                                                                                   | d by           | Vegener's gro                                                                                                                                                                                                        |                                                                                       |                                                   |                                                             | 101                                                                              | res 2 No 3 P                               | robabiy 4 Unknown                                     |  |  |  |  |
| 000               | s been si                                                                                                                                                                                                                                                 | olete          | 5                                                                                                                                                                                                                    |                                                                                       |                                                   |                                                             | 24a. Was                                                                         | an 24b. Were a                             | utopsy findings available                             |  |  |  |  |
| æ                 | The la                                                                                                                                                                                                                                                    | Completed      |                                                                                                                                                                                                                      |                                                                                       |                                                   |                                                             |                                                                                  | osy prior to death?                        | completion of cause of                                |  |  |  |  |
| <u>ia</u>         | artifice<br>ctor, p                                                                                                                                                                                                                                       | Bec            | 25. Was case referred to medical examiner?                                                                                                                                                                           |                                                                                       |                                                   | 26. Place of De                                             | ath (Check only o                                                                |                                            |                                                       |  |  |  |  |
| <u>~</u>          | hysic<br>this ca                                                                                                                                                                                                                                          | 2              | 1 Yes 28 No                                                                                                                                                                                                          |                                                                                       | ER/Outpatient 3                                   | DOA Other: 4 Nursing                                        | Home 5 Resid                                                                     | dence 6 Other (Spe                         | cify)                                                 |  |  |  |  |
| Division of Vital | ling P                                                                                                                                                                                                                                                    | on:            | 27. Manner of Death Natural 5 Pending                                                                                                                                                                                | 28a. Date of Injury<br>(Month, Day Year)                                              | 28b. Time of<br>Injury                            | 28c. Injury at<br>Work?                                     |                                                                                  | now injury occurred                        |                                                       |  |  |  |  |
| Si                | death.<br>ctor: A<br>y the fu                                                                                                                                                                                                                             | Icat           | 2 Accident investigation 3 Suicide 6 Could not be                                                                                                                                                                    | 28e. Place of Injury - At ho                                                          | M form street fact                                | 1 Yes 2 No                                                  | 29f Location /6                                                                  | (Street and Alumbar or Burst Pauls Alumbar |                                                       |  |  |  |  |
| É                 | after<br>Dire                                                                                                                                                                                                                                             | Certification: | 4 Homicide determined                                                                                                                                                                                                | building, etc. (Specifi                                                               | y)                                                | ory, onice                                                  | office 28f. Location (Street and Number or Rurat Route Numb City or Town, State) |                                            |                                                       |  |  |  |  |
|                   | To the Hospital or Attending Physicien: The law within 24 bours after death, within 24 bours after death.  To the Funeral Director: After this cardificate has completely filled in by the funeral director, page 2                                       | Medical C      | 29a. Certifier (Check only one) Certifying Ph-                                                                                                                                                                       | ysicien: To the best of my kno<br>iner: On the basis of examina<br>and manner stated. | cause(s) and manner as<br>date and place, and due | s stated.<br>a to the cause(s)                              |                                                                                  |                                            |                                                       |  |  |  |  |
|                   | To the Vithin 2 To the Complet                                                                                                                                                                                                                            | Me             | 29b. Signature and title of certifier                                                                                                                                                                                |                                                                                       |                                                   | 9c. License number                                          |                                                                                  | 29d. Date signed (Month, Day, Year)        |                                                       |  |  |  |  |
| )                 |                                                                                                                                                                                                                                                           |                | 1 Ad                                                                                                                                                                                                                 | m m                                                                                   |                                                   | D51735                                                      |                                                                                  | 21187                                      | X                                                     |  |  |  |  |
|                   | 15                                                                                                                                                                                                                                                        |                | 30. Name and address of person who o                                                                                                                                                                                 |                                                                                       | 23a) (Type, Print)                                | -REDERICK 9                                                 |                                                                                  | 1.000                                      | <u> </u>                                              |  |  |  |  |
|                   |                                                                                                                                                                                                                                                           |                | 6602 Ch                                                                                                                                                                                                              | unchaill &                                                                            | Ld See                                            | ite zoal                                                    | hedeet                                                                           | sen MD                                     | 21620                                                 |  |  |  |  |
|                   | Sta<br>Registr                                                                                                                                                                                                                                            |                | 31. Date filed (Month, Day, Year)                                                                                                                                                                                    | 32. Registar's Signa                                                                  | ature                                             |                                                             |                                                                                  |                                            |                                                       |  |  |  |  |

|                                                                                                                                                                                                                                                                                                                    | State of Maryland / Department / Department / Department / Department / Department / Department  | rtificate of Death                                                                                  | Reg. No. 2000 0000                                                                                           |  |  |  |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|
| Physician                                                                                                                                                                                                                                                                                                          | Decedent's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                     | 2. Date of Death Nonth Day Year 3. Time of Death                                                             |  |  |  |  |  |  |  |
| /Medical                                                                                                                                                                                                                                                                                                           | Joseph Bernard Stephens, Jr.  4a. Facility Name (If not institution, give street and number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4b. City, Town, or Location of Death                                                                | February 10, 2008   12:10 A M   4c. County of Death                                                          |  |  |  |  |  |  |  |
| Examiner                                                                                                                                                                                                                                                                                                           | Golden Living Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Westminster                                                                                         | Carroll                                                                                                      |  |  |  |  |  |  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                | 5. Social Security Number 219–12–7009 6. Sex 1 MM 2 F 7. Age (In yrs. last birthday) 84 Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.                                   | 8. Date of Birth (Month, Day, Year)  Jan. 6, 1924  8. Birthplace (State or Foreign Country)  Maryland        |  |  |  |  |  |  |  |
| yland<br>now<br>at                                                                                                                                                                                                                                                                                                 | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                     | 10d. Inside City Limits                                                                                      |  |  |  |  |  |  |  |
| vith the Marior 28a-f sh                                                                                                                                                                                                                                                                                           | Maryland Carroll Westminst                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                     | 1 □Yes 2 No                                                                                                  |  |  |  |  |  |  |  |
| 23a or 2<br>ust be ng                                                                                                                                                                                                                                                                                              | 10e. Street and Number 509 East Old Baltimore Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 10f. Zip Code 21157                                                                                 | 10g. Citizen of What Country? United States                                                                  |  |  |  |  |  |  |  |
| Nore, Maryland 21215-0036  ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director | 3 ☐ Widowed 4 ※ Divorced   If Yes, Give Year or Dates: WW II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify: | pecify Yes or No-<br>o Rican, etc.)  14. Race - American Indian,<br>Black, White, etc.  Specify: White       |  |  |  |  |  |  |  |
| "natur<br>"natur<br>edical                                                                                                                                                                                                                                                                                         | 15. Decedent's Education 16a. Dece<br>(Specify only highest grade completed) (Give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | dent's Usual Occupation<br>a kind of work done during most of work<br>DO NOT use retired)           | 16b. Kind of Business/Industry                                                                               |  |  |  |  |  |  |  |
| 21215-0036 ed within 72 hours af ygiene. ner than "natural", or it, the Medical Exam Completed by F                                                                                                                                                                                                                | Elementary/Secondary (0-12) College (1-4or 5+) finar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | nce manager                                                                                         | finance company                                                                                              |  |  |  |  |  |  |  |
| Maryland 2 d 2 should be filed th and Mental Hygi ?? is marked other traumatic event, ti                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                     | ne (First, Middle, Maiden Surname)<br>izabeth Lee                                                            |  |  |  |  |  |  |  |
| Mary<br>d 2 sho<br>th and 1<br>7 is me<br>traume                                                                                                                                                                                                                                                                   | 19a. Informant's Name/Relationship (Type. Print) 19b. Maili                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | = :                                                                                                 | ural Route Number, City or Town, State, Zip Code)  Nottingham, Maryland 21236                                |  |  |  |  |  |  |  |
| Baltimore, M Jermit. Pages 1 and 2 Department of Health Important: If item 27 i any lnjury or other tre once.                                                                                                                                                                                                      | 20a. Method of Disposition  1 M Rurial 2 Cremation 3 D Bemoval from State  20b. Place of Disposition cemetery, cre                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | osition (Name of matory or other place) Feb.                                                        | Date 20c. Location - City or Town, State                                                                     |  |  |  |  |  |  |  |
| Baltimc permit. Page Department of Important: If any Injury or once.                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Lice Lee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                     | line Funeral Home                                                                                            |  |  |  |  |  |  |  |
| <b>6</b>                                                                                                                                                                                                                                                                                                           | 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | nter the mode of dying, such as cardiac                                                             | c or respiratory arrest, Approximate Interval Between Onset and Death                                        |  |  |  |  |  |  |  |
| Physician /<br>/Medical                                                                                                                                                                                                                                                                                            | Immediate Cause (Final disease or condition resulting in death)  a. Alzheirsul durunta 340-45                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                     |                                                                                                              |  |  |  |  |  |  |  |
| Examiner                                                                                                                                                                                                                                                                                                           | Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | example of the second second                                                                        |                                                                                                              |  |  |  |  |  |  |  |
| o,<br>executed<br>an and<br>rial-transit<br>Examiner                                                                                                                                                                                                                                                               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | artery di                                                                                           | sense 6 years                                                                                                |  |  |  |  |  |  |  |
| 68760, tificate be executed g physician and as the burial-transit                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                     |                                                                                                              |  |  |  |  |  |  |  |
| death cer e attendir d for use                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | □Ectopic pregnancy □ Other (specify)                                                                | 23d. Date of delivery  Month Day Year                                                                        |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | underlying cause given in Part I.                                                                   | 23e. Did tobacco use contribute to the cause of death?                                                       |  |  |  |  |  |  |  |
| require<br>teen sig<br>should b                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 Yes 2 No 3 Probably 4 Unknown                                                                     |                                                                                                              |  |  |  |  |  |  |  |
| Re law e has ge 2                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                     | 24a. Was an autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No                |  |  |  |  |  |  |  |
| Or Vital Physician: This certifica ral director, p                                                                                                                                                                                                                                                                 | examiner?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Othor                                                                                               | ath <i>(Check only one)</i> Home 5 ☐ Residence 6 ☐ Other <i>(Specify)</i>                                    |  |  |  |  |  |  |  |
| on or ding Phy h. After this funeral d                                                                                                                                                                                                                                                                             | On Detect Initial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | of 28c. Injury at                                                                                   | 28d. Describe how injury occurred                                                                            |  |  |  |  |  |  |  |
| Division or Vital Ital or Attending Physician: rs after death. ral Director: After this certification by the funeral director, p                                                                                                                                                                                   | Thatural 5 Pending 1 Pending 2 Accident investigation 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 Pending 1 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 Pending 1 Homicide 5 P |                                                                                                     |                                                                                                              |  |  |  |  |  |  |  |
| Divisio  To the Hospital or Attend within 24 hours after death.  To the Funeral Director: A completely filled in by the fu                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ath occurred at the time, date and plac<br>investigation, in my opinion, death occ                  | e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s) |  |  |  |  |  |  |  |
| To the comple                                                                                                                                                                                                                                                                                                      | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 29c. License number  \$\mathcal{D}\$  \( \tau \)  \( \tau \)                                        | 29d. Date signed (Month, Day, Year)                                                                          |  |  |  |  |  |  |  |
| HTINA                                                                                                                                                                                                                                                                                                              | 30. Name and address of person who completed cause of death (Item 23a) (Type M. PANSURIYA 349 Malus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Print)                                                                                              | est minstor MD 21157                                                                                         |  |  |  |  |  |  |  |
| State<br>Registrar                                                                                                                                                                                                                                                                                                 | 31. Date filed (Month, Day, Year) 32. Registrar's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Sparke                                                                                              |                                                                                                              |  |  |  |  |  |  |  |
| DHMH 17 Rev 1/2001                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RIGINAL                                                                                             |                                                                                                              |  |  |  |  |  |  |  |

### Amended Item 26 per Physician 02/11/2008 Carroll County, wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Albert John Schubert 7:00 p 2008 February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Elternhaus Dayton Howard 8. Date of Birth (Month, Day, Ye July 11, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign , 1912 Maryland Months 1**⊠**M 2□F Days Hours Min. 95 214-03-2659 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Westminster 1 ☐ Yes 2 No Maryland Carroll 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21157 33 Shamrock Circle USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify: 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Production Manager Manufacturing 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Schubert Margaret Schleuter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack L. Schubert, son 33 Shamrock Circle, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 █ Burial 2 □ Cremation 3 □ Removal from State 2/11/2008 Woodlawn, MD Woodlawn Cemetery 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Service License 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 KOL

Physician /Medical Examiner

death certificate be executed

Box 68760.

P.O.

Division or Vital Records,

or Attending

permit. Page Department of Important: If any Injury or

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

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nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygiene.
artment of Health and Mental Hygiene.
ordrant: If Items Imarked other than "hatural", or items 23a or 28a-f show in In In or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

the burial-transit Exami physician Physician/Medical as attending for use the detached signed by I þ 2 should Completed has page funeral director, Be ပို After this Certification: death. the filled in by

27. Manna of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB

11

5 Pending

investigation

6 ☐ Could not be determined

1 Natural

within 24 hours after death To the Funeral Director: Hospital the WJZ

23a. Part1\Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) zheime Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residences Sisted Lijving 1 Tes 1 🔲 Inpatient **→** 3 🗆 DOA 28a. Date of Injury (Month, Day Year)

28c. Injury at Work?

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Charke Dr Columbia

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State Registrar

Medical

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

manner stated.

10700

32. Egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Riesett

2008

Injury

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 12,2008 0:00 A M FEBRUARY ARV 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RSTONE lymbia 0 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□M 2<mark>X</mark>F Months Days Hours 474-52-1377 92 22, 1915 Washington Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ∐Yes 2 No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21045 5037 Netherstone Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Owen Kinnard Edna Metcalf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen B. Dunlop/daughter 5033 Netherstone Court Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 02/13/08 |Beltsville, MD 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licenses MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BACTERIAL ENOUCARDITYS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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"natural", or items 23a or edical Examiner must be r

the Medical

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nt of Health a t: If Item 27 Is r or other tra

permit. Page Department of Important; If any Injury or

Pages '

Director MD

Funeral

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Completed

Be

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be executed burial-trar and attending physician for use as the buris ed by the a page 2 s certificate Physician: director this After or Attending

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical Be Completed by Certification: To

IN SUFFICIENCY VALVE 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

E.G.

To the Hospina. Swithin 24 hours after death To the Funeral Director Plately filled in by the

after death

State

Registrar

Medical

29b. Signature and title

30. Name and address of person who

MAUREL 2008

STE. 16 GLENWOOD MO

death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Suk Y Suh 2008 1:00 /Medical February Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6150 Foreland Garth Apt403 Columbia Howard 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Sex XXM 2□F Days Hours Months 217-94-0234 Director 85 12/29/1922 South Korea Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits Director Md. Howard Columbia 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Examiner must be r 6150 Foreland Garth 21045 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2€ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify à Specify: 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) rthan the M Elementary/Secondary (0-12) College (1-4or 5+) Engineer Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Suh Yoon-Kun P Kim Bo-Yeon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elise Ma/daughter 4588 Kingscup Ct. Ellicott City, Md. 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of P Important: If Ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify, Crest Lawn Cemetery 2/14/2008 Marriottsville,Md. 21. Signature of Funeral Service 22. Name and Address of FacilitHarry H.Witzke's Family F.H.Inc. MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) oronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical as attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒No 24a. Was an page 2 s autopsy performe 2 X No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 | Inpatient 2 ER/Outpatient Certification: To 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician:

within 2

29b. Signature and title of certifie

31. Date filed

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distrar's Signatur

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

2008

29c. License number

29d. Date signed (Month, Day, Year)

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|                                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                   | The Control of the Co |                         |               |                |                                  |                                       |                                                                                                                   |                            | Reg. No.                   | 7,000                                                                       |                                             |                                                                                 |                              |                     |          |
| Н                              | Physicia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ın                                                                                | 1. Decedent's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |               |                |                                  |                                       | Month                                                                                                             |                            |                            |                                                                             | Month                                       | Day Year                                                                        |                              |                     |          |
| 135                            | /Medical Jacob Stempel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            | Februa                                                                      | _                                           | , 2008                                                                          | 6:30 P                       | 'M                  |          |
|                                | Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | er                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |               |                |                                  |                                       | 4b. City, Town, or Location of Death                                                                              |                            |                            |                                                                             |                                             |                                                                                 | County of Dea                |                     |          |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2 Watchwater Way  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |               |                |                                  | If Under                              |                                                                                                                   | ille                       | 24 Hrs.                    | 8. Date of Birt                                                             | montgomery  9. Birthplace (State or Foreign |                                                                                 |                              | Foreign             |          |
|                                | Funeral Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                   | 1X M 2 F Yrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |               |                | Months Days Hours Min. (Month, D |                                       |                                                                                                                   |                            | (Month, Da<br>2/16/1       | y, Year)                                                                    | Year) Country)                              |                                                                                 |                              |                     |          |
|                                | om Beddingslige in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   | 540-40-56<br>Usual Residence of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |               |                | 71                               |                                       |                                                                                                                   |                            | 1                          |                                                                             | 2/10/1                                      | 930                                                                             | Germany                      |                     |          |
|                                | /land<br>ow<br>at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                   | 10a. State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 10b. County             |               |                | 10c. City                        | , Town or Lo                          | cation                                                                                                            |                            |                            |                                                                             |                                             |                                                                                 |                              | 10d. Inside City    | Limits   |
|                                | Mar<br>fied                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ģ                                                                                 | MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Montg                   | omery         |                | Roc                              | kville                                |                                                                                                                   |                            |                            |                                                                             |                                             |                                                                                 |                              | Y∏Yes 2             | ! No     |
|                                | r 28a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Director                                                                          | 10e. Street and Nun                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | nber                    | · · · ·       |                |                                  |                                       | 10f. Zip Code                                                                                                     |                            |                            |                                                                             |                                             | 10g. Cit                                                                        | 0g. Citizen of What Country? |                     |          |
|                                | h with                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | =                                                                                 | 2 Watchwater Way                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |               |                |                                  | 208                                   | 350                                                                                                               |                            |                            |                                                                             |                                             | United States                                                                   |                              |                     |          |
|                                | ms 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Funeral                                                                           | 11. Marital Status                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 12. Wa        | s Deceden      | t Ever in U.                     | S. 13. \                              | Was Deced                                                                                                         | dent of Hi                 | spanic Orig                | gin? (Spe                                                                   | cify Yes or No<br>Rican, etc.)              |                                                                                 | 14. Race - Am<br>Black, Whi  |                     |          |
| ဖ                              | after<br>or ite                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2                                                                                 | 1 Never Marri                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ed 🚜 Marr               | ried TV       | Yes 2 ces      | 1 No                             |                                       |                                                                                                                   |                            | Specify:                   | , rueito t                                                                  | iicari, etc.)                               |                                                                                 |                              |                     |          |
| 8                              | ral",                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | þ                                                                                 | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1959—19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |               | 9-1960         | 1 163                            | -X-140                                | ореспу.                                                                                                           |                            |                            | Specify: White                                                              |                                             |                                                                                 |                              |                     |          |
| 5-0                            | 72 honatu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Completed                                                                         | 15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |               |                | 16a. Deced<br>(Give              | dent's Usua<br>kind of wo             | al Occupa<br>rk done o                                                                                            | ation<br>during most<br>f) | of working                 | ng                                                                          |                                             | ind of Business<br>er-Ame                                                       |                              |                     |          |
| 2                              | ithin<br>ne.<br>nan "<br>e Me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | dr.                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |               |                |                                  |                                       |                                                                                                                   | )<br>: Bank                |                            |                                                                             |                                             | elopmen                                                                         |                              |                     |          |
| 7                              | led w<br>lygie<br>her ti<br>nt, th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   | 17. Father's Name (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Cinch Adiabatic         |               |                |                                  |                                       |                                                                                                                   |                            |                            |                                                                             | (First, Middle                              |                                                                                 |                              |                     |          |
| Baltimore, Maryland 21215-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Be                                                                                | Joseph S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            |                                                                             | reiber                                      | Maiden                                                                          | r ourname)                   |                     |          |
| Ĕ                              | hould<br>d Me<br>nark<br>natic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | မ                                                                                 | 19a. Informant's Na                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ma/Palations            | hin /Time Pri | nt)            |                                  | 10h Mailir                            | an Addraes                                                                                                        | (Street s                  | and Numbe                  | or or Rura                                                                  | l Route Numb                                | er City (                                                                       | or Town, State,              | Zin Code)           |          |
| Ma                             | and 2 should<br>saith and Mer<br>n 27 Is marke<br>ler traumatic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                   | Hilde R.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |               |                |                                  | 1                                     | _                                                                                                                 | •                          |                            |                                                                             | 11e MD                                      | -                                                                               |                              | Lip dodd)           |          |
| Ġ,                             | 1 an<br>Heal<br>em 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                   | 20a. Method of Disp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |               |                | 20b. P                           | Place of Dispo                        | sition (Nar                                                                                                       | ne of                      | -                          |                                                                             | ate                                         |                                                                                 | ocation - City o             | r Town, State       |          |
| <u>o</u>                       | ages<br>ent of<br>t: If it                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                   | 1 □ Burial 2 [<br>4 □ Donation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |               | I from Stat    | e Gar                            | den of<br>Me                          | Reme                                                                                                              | emp Ra                     | nçe                        | 2/11                                                                        | /2008                                       | C1                                                                              | arksbu                       | a MD                |          |
| ≣                              | permit. Pages 1 and 2<br>Department of Health a<br>Important: If Item 27 Is<br>any Injury or other tra                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                   | 21. Signature of Fu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |               |                | - 1                              | 22                                    | 2. Name ar                                                                                                        | nd Addres                  | ss of Facilit              | v                                                                           |                                             |                                                                                 |                              |                     |          |
| m                              | Dep<br>Imp<br>any                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                   | Edward Sagel Funeral Direction Inc 20852                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            |                                                                             |                                             |                                                                                 |                              |                     |          |
|                                | 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                   | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lige.  Immediate Cause (Final Acute Leukemia disease or condition a Hyelodysplastic Syndrome                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            | Approximate<br>Interval Between                                             | een                                         |                                                                                 |                              |                     |          |
|                                | Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            |                                                                             | 1 Month                                     | hs.                                                                             |                              |                     |          |
|                                | /Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                   | resulting in death)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |               |                | is a consequ                     |                                       | HULST                                                                                                             | i.c.                       |                            |                                                                             |                                             |                                                                                 |                              | O MORE              | -        |
| 1                              | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                   | Sequentially list conditions by Myelodysplastic Syndrome                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |               |                |                                  |                                       |                                                                                                                   |                            | 8 mont                     | ths                                                                         |                                             |                                                                                 |                              |                     |          |
|                                | D =                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Examiner                                                                          | Sequentially list conditions, it any, leading to infinited accuses. Enter Underlying Cause (Disease or injury that initiated events  c.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            |                                                                             |                                             |                                                                                 |                              |                     |          |
| ,                              | ecute<br>and<br>trans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                   | Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            |                                                                             |                                             |                                                                                 |                              |                     |          |
| 8760,                          | cate be executed obligations and the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | E                                                                                 | Due to (or as a consequence of).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            |                                                                             |                                             |                                                                                 |                              |                     |          |
| 87                             | icate be executed<br>physician and<br>the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | dical                                                                             | d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            |                                                                             |                                             |                                                                                 |                              | -                   |          |
| 9 X                            | ding de as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Physician/Me                                                                      | IF FEMALE: 23c. If yes, outcome pf pregnancy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            |                                                                             | - N                                         | 23d. Date of delivery<br>Month Day                                              |                              | olivon.             |          |
| Вох                            | leath certific<br>attending p                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ian                                                                               | in the past 12 months?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |               |                |                                  | ☐ Ectopic pregnancy ☐ Other (specify) |                                                                                                                   |                            |                            | -                                                                           | ear                                         |                                                                                 |                              |                     |          |
| P.0.                           | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ysic                                                                              | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            |                                                                             |                                             |                                                                                 |                              |                     |          |
| ٣.                             | w requires that the d<br>been signed by the<br>should be detached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | H H                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |               |                |                                  |                                       |                                                                                                                   |                            | ven in Part I. 23e. Did to |                                                                             |                                             | obacco use contribute to the cause of death?                                    |                              |                     |          |
| g                              | luires<br>1 sigr<br>Ild be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | d by                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |               |                |                                  |                                       |                                                                                                                   |                            | 1                          |                                                                             |                                             | Yes 2X No 3 Probably 4 Unknown                                                  |                              |                     | nknown   |
| <u>0</u>                       | w red<br>beer<br>shou                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | lete                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            |                                                                             | 24a. Was                                    | an                                                                              | 24b. Were                    | autopsy findings av | vailable |
| Re                             | Physician: The law<br>r this certificate has t<br>ral director, page 2 s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Completed                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |               |                |                                  | ***                                   |                                                                                                                   |                            |                            |                                                                             | auto                                        | psy<br>ormed?                                                                   | prior to<br>death            |                     | use of   |
| ta                             | in: T                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                   | 25. Was case refer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | red to medica           |               |                |                                  |                                       |                                                                                                                   |                            | 26 Place                   | of Death                                                                    | performed? death?  1 Yes 2 No 1 Yes 2 No    |                                                                                 |                              |                     |          |
| >                              | Physician:<br>r this certific<br>ral director,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | o Be                                                                              | examiner?<br>1 ☐ Yes 2 🗓                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | Hospita       | l:<br>1 ∏ Inpa | tient 2 □                        | ER/Outpatie                           | nt 3 🗆 D0                                                                                                         | Oth                        | or:                        | lace of Death (Check only one)  Nursing Home 5X Residence 6 Other (Specify) |                                             |                                                                                 |                              |                     |          |
| ŏ                              | g Phy<br>erthi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | n: To                                                                             | 27. Manner of Deat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | h                       |               | . Date of Ir   | njury<br>Day Year)               | 28b. Time o                           |                                                                                                                   | 28c. Injur<br>Worl         |                            |                                                                             | 28d. Describe                               |                                                                                 |                              |                     |          |
| <u>o</u>                       | ndin<br>ath.<br>r: Aft                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | atio                                                                              | 1 X Natural 2 ☐ Accident                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5 ☐ Pendir<br>investi   | ng<br>igation | (WOHTH, L      | Jay real)                        | Injury                                | M                                                                                                                 |                            | Yes 2                      | No                                                                          |                                             |                                                                                 |                              |                     |          |
| Division or Vital Records,     | r Atte<br>er dea<br>recto<br>by th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ifica                                                                             | 3 ☐ Suicide<br>4 ☐ Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 6 ☐ Could determ        |               | . Place of i   | injury - At ho                   | ome, farm, str                        | reet, factor                                                                                                      | y, office                  |                            | 2                                                                           | 28f. Location (                             | ocation (Street and Number or Rural Route Number, ity or Town, State)           |                              |                     |          |
|                                | ital or<br>rs afte<br>rai Di                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Certification:                                                                    | City of Torrit, Galley                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            |                                                                             |                                             |                                                                                 |                              |                     |          |
|                                | To the Hospital or Attending Phys, within 24 hours after death.  To the Funeral Director; After this completely filled in by the funeral dir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ical                                                                              | 29a. Certifier<br>(Check only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1 X Certifyli 2 Medical | Examiner: O   | n the basis    | of examina                       | owledge, deat<br>ation and/or ir      | ath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time |                            |                            |                                                                             | and due to the<br>ed at the time            | ne cause(s) and manner as stated.<br>e, date and place, and due to the cause(s) |                              |                     |          |
|                                | the thin 2 | Medical                                                                           | one) 29b. Signature and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | attle of certifie       |               | d manner       | stated.                          |                                       |                                                                                                                   |                            |                            |                                                                             | 29d. Da                                     | ate signed (Mo                                                                  | nth, Day, Year)              |                     |          |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                   | 1//                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | istail                  | MILLE         | 200            |                                  |                                       |                                                                                                                   | 2330                       | )8                         |                                                                             |                                             | 29d. Date signed (Month, Day, Year) February 11, 2008                           |                              |                     |          |
|                                | 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   | 30. Name and addr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | rass of parson          | wo complete   | ed cause o     | f death (Iten                    | n 23a) (Type                          | Print)                                                                                                            |                            |                            |                                                                             |                                             |                                                                                 | <b>J</b>                     | , _,                |          |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                   | Dr. Vict                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |               |                |                                  |                                       |                                                                                                                   | ive.                       | Suit                       | te 41                                                                       | 00. R                                       | ethe                                                                            | esda, M                      | 20817               |          |
|                                | Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ite                                                                               | 31. Date filed (Mon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | th, Day, Year           | )             | 32 Regis       | strar's Signa                    | ature                                 | ا گھا                                                                                                             | ,                          |                            | _ T.L                                                                       | 50 <b>9</b> D                               | 110                                                                             | TII e sous                   |                     |          |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ar                                                                                | 31. Date filed (Month, Day, Year) FEB 1 3 2008  37 Registrar's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |               |                |                                  |                                       |                                                                                                                   |                            |                            |                                                                             |                                             |                                                                                 |                              |                     |          |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 10:55 A.M Emi1 Siltman David February 8, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9600 Shadow Oak Drive Montgomery Village Montgomery ear If Under 24 Hrs. 8. Date of Birth
Aus Hours Min. (Month, Day, Year)
July 30,1931 Birthplace (State or Foreign Country)
 TX 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 □ F 458-44-1526 76 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f show r 28a-f show notified at 1 ☐ Yes 2 X No Director MD Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Examiner must be 9600 Shadow Oak Drive 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1954-3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: Specify: White 2 3 Widowed 4 Divorced 1956 Completed of Health and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the M-dical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) I.B.M. Programmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emil Hugo Siltman Maebelle Skinner ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Vaughn Siltman/Spouse 9600 Shadow Oak Drive, Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H ant: If ite 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. February 11 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licer 22. Name and Address of Facility DeV01 Funeral Home, 10 East Deer Park Drive Gaithersburg, MD 20877 TRACY A STUVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Hanging wo OME disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transil resulting in death) Last Due to (or as a consequence of): 7 Division or Vital Records, P.O. Box 68760, 11 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2**X** No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1

Yes 2

No Other: 4 Nursing Home 5 \$\foat \text{Residence} 6 Other (Specify) Hospital: ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Unk M self 1 Tes 8 2008 neral Director: / 2 Accident 3X Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Ri City or Town, State) 9 600 5 4 ☐ Homicide 10mg Gaithersburg mD 20889 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier D0035854 February 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 12

2008

Leszek Karowiec, M.D., 501 N. Frederick Avenue, #200, Gaithersburg, MD 20877

Registrar's Signature

|                            |                                                                                                                                                                                                                                                                     | ·                 | For State Registrar                                                                                                                                        | State of Marylan                                                                              |                                          | ent of He                         |                                      |                                      | ene.<br>2008                    | 06074                                              |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------|--------------------------------------|--------------------------------------|---------------------------------|----------------------------------------------------|
|                            | Physici                                                                                                                                                                                                                                                             | _                 | 1. Decedent's Name (First, Middle, Last                                                                                                                    | Sanders                                                                                       |                                          |                                   |                                      | 2. Date of Death<br>Month            | Pay Year                        | 3. Time of Death                                   |
|                            | /Medic<br>Examin                                                                                                                                                                                                                                                    |                   | 4a. Facility Name (If not institution, give                                                                                                                |                                                                                               | 4b. (                                    | City, Town, or Lo                 | ocation of Death                     | 2/12/                                | 4c. County of Death             |                                                    |
|                            |                                                                                                                                                                                                                                                                     |                   | Washington                                                                                                                                                 | Adventist                                                                                     | Hosp. To                                 | akom                              | ia Pa                                | rK                                   | Montgo                          | mery                                               |
|                            | Funeral<br>Director                                                                                                                                                                                                                                                 |                   | 5. Social Security Number 6. Se 228 62 9226                                                                                                                | 7. Age (In yrs. 59                                                                            | / Yrs. If U                              |                                   | f Under 24 Hrs.<br>Hours Min.        | 8. Date of Birth<br>Month, Day, Y    | (ear) 9. Birth                  | place (State or Foreign Intry)                     |
|                            | pu .                                                                                                                                                                                                                                                                |                   | Usual Residence of Decedent  10a. State 10b. County                                                                                                        | 10c Cit                                                                                       | y, Town or Location                      |                                   |                                      |                                      |                                 | 10d. Inside City Limits                            |
|                            | Maryla<br>f show                                                                                                                                                                                                                                                    | JO.               | MD Paince                                                                                                                                                  | Georges P                                                                                     | owie                                     |                                   |                                      |                                      |                                 | 1 ☐ Yes 2 MiNo                                     |
|                            | r 28a                                                                                                                                                                                                                                                               | irec              | 10e. Street and Number                                                                                                                                     | <u>Craiga</u> —                                                                               |                                          | . Zip Code                        |                                      | 100                                  | . Citizen of What Cou           | intry?                                             |
|                            | 23a c                                                                                                                                                                                                                                                               | Funeral Director  | 155 22 N. N                                                                                                                                                | emo Cou                                                                                       | xt 2                                     | 2071                              | 6                                    |                                      | USA                             |                                                    |
|                            | er dez                                                                                                                                                                                                                                                              | nue               | 11. Marital Status                                                                                                                                         | 12. Was Decedent Ever in U. Armed Forces?                                                     | S. 13. Was D<br>If Yes,                  | ecedent of Hisp<br>specify Cuban, | anic Origin? (Spe<br>Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)     | 14. Race - Amer<br>Black, White |                                                    |
| 036                        | s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at | þ                 | 1 Never Married 2 Married 3 Widowed 4 Divorced                                                                                                             | 1 XYes 2 □ No<br>trYes, Give 3119<br>Year or Dates: 1120                                      | 171- 1 Ye                                | s 2 No                            | Specify:                             |                                      | Specify: B                      | lack                                               |
| 5-0036                     | 72 ho<br>'natur                                                                                                                                                                                                                                                     | Completed         | 15. Decedent's Edu<br>(Specify only highest grad                                                                                                           | ucation                                                                                       | 16a. Decedent's<br>(Give kind o          | f work done dur                   | on<br>ring most of works             | ng 16                                | b. Kind of Business/I           | ndustry                                            |
| 2121                       | within iene.                                                                                                                                                                                                                                                        | mpi               | Elementary/Secondary (0-12)                                                                                                                                | College (1-4or 5+)                                                                            | E E C                                    | OT use retired)                   | nselo                                | 1                                    | 18 (30)                         | ernment                                            |
|                            | illed<br>I Hygid<br>other                                                                                                                                                                                                                                           | Be Co             | 17. Father's Name (First, Middle, Last)                                                                                                                    |                                                                                               |                                          |                                   | 1-010                                | (First, Middle, Ma                   |                                 | CHIT ONE                                           |
| Maryland                   | should be<br>and Mental<br>Is marked of<br>aumatic eve                                                                                                                                                                                                              | To B              | Lalon Sar                                                                                                                                                  | iders                                                                                         |                                          | Ī                                 | Bessi                                | e Dr                                 | inkar                           | d                                                  |
| Man                        | 2 sho                                                                                                                                                                                                                                                               |                   | 19a. Informant's Name/Relationship (T                                                                                                                      | ype, Print)                                                                                   |                                          |                                   |                                      |                                      | City or Town, State, Z          | ~                                                  |
|                            | of Health<br>item 27<br>other tra                                                                                                                                                                                                                                   |                   | 20a. Method of Disposition                                                                                                                                 | nders/Wite                                                                                    | lace of Disposition                      | (Name of                          | mo Coc                               |                                      | oc. Location - City or 1        | OM, State                                          |
| nor                        | 00-2                                                                                                                                                                                                                                                                |                   | 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify                                                                                                | Removal from State                                                                            | emetery, crematory<br>L <b>i tenh</b> am | or other place)                   | m. 2/25                              | 1 4                                  | ,                               | am. MD                                             |
| Baltimore,                 | orts                                                                                                                                                                                                                                                                |                   | 21. Signature of Funeral Service Licens                                                                                                                    |                                                                                               |                                          |                                   |                                      |                                      | uneral                          | Home                                               |
| 8                          | Pen<br>fmp<br>gny                                                                                                                                                                                                                                                   |                   | > nels &                                                                                                                                                   | Some                                                                                          | 1814                                     |                                   |                                      |                                      | exandria                        |                                                    |
| 1.                         | Physician<br>/Medical                                                                                                                                                                                                                                               |                   | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of<br>Immediate Cause (Finat<br>disease or condition<br>resulting in death)   | a. Sepsis                                                                                     | h. Do not enter the uence of):           | mode of dying,                    | such as cardiac o                    | or respiratory arres                 | t,                              | Approximate<br>tnterval Between<br>Onset and Death |
| 0,                         | Examiner sician and burial-transit                                                                                                                                                                                                                                  | Examiner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Cardio M  Use to (or as a consort  C. Due to (or as a consort                              | ge ren                                   | al a                              | lescoure                             |                                      |                                 |                                                    |
| 8760                       | cate be<br>ohysici<br>the bu                                                                                                                                                                                                                                        | dicai             |                                                                                                                                                            | d                                                                                             |                                          |                                   |                                      |                                      |                                 |                                                    |
| .O. Box 6                  | The law requires that the death certificate be executed to hes been signed by the attending physician and bage 2 should be detached for use as the burial-transit                                                                                                   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1                                                                                             | 23c. If yes, outcome of pregna<br>1□Live birth 2□Feta<br>4□Pregnant at time of d<br>9□Unknown | t death 3 Ectop                          | oic pregnancy<br>or (specify)     |                                      |                                      | 23d. Date of deli<br>Month      | very<br>Day Year                                   |
| <u>α</u>                   | uires that t<br>signed by<br>id be detail                                                                                                                                                                                                                           | by                | Part tt. Other significant conditions co                                                                                                                   | intributing to death but not res                                                              | utting in the underly                    | ing cause given                   | in Part I.                           |                                      | cco use contribute to           |                                                    |
| Division of Vital Records, | ne taw requir<br>hes been si<br>ge 2 should I                                                                                                                                                                                                                       | Completed         |                                                                                                                                                            |                                                                                               |                                          |                                   |                                      | 24a. Was an autopsy performe         | prior to death?                 | topsy findings available<br>completion of cause of |
| tal                        |                                                                                                                                                                                                                                                                     | င်                | 25. Was case referred to medical                                                                                                                           |                                                                                               |                                          | 2                                 | 6 Place of Death                     | 1 Yes 21                             |                                 | 2 □ No                                             |
| i V                        | dis di                                                                                                                                                                                                                                                              | To B              | examiner?                                                                                                                                                  | Hospital: 1 Inpatient 2                                                                       | ER/Outpatient 3[                         | DOA Other:                        |                                      |                                      | ce 6 ☐Other (Spec               | cify)                                              |
| 0 U                        | ding Ph<br>h.<br>After th<br>funeral                                                                                                                                                                                                                                |                   | 27. Mann of Death 1 Natural 5 ☐ Pending                                                                                                                    | 28a. Date of tnjury<br>(Month, Day Year)                                                      | 28b. Time of<br>Injury                   | 28c. Injury a<br>Work?            |                                      | 28d. Describe how                    | injury occurred                 |                                                    |
| ivisio                     | tend<br>death<br>tor:<br>the                                                                                                                                                                                                                                        | Certification:    | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined                                                                                    |                                                                                               | ome, farm, street, fa                    |                                   | s 2 No                               | 28f. Location (Stre<br>City or Town, | net and Number or Ru<br>State)  | ral Route Number,                                  |
|                            | To the Hospital or Al<br>within 24 hours after of<br>To the Funeral Dirsc<br>completely filled in by                                                                                                                                                                |                   | 29a. Certifier 1 Certifying Phy                                                                                                                            | ysician: To the best of my kno                                                                |                                          | rred at the time,                 | , date and place,                    | and due to the cau                   | ise(s) and manner as            | stated.                                            |
|                            | the Ho<br>Fin 24 f<br>the Fu<br>mpletely                                                                                                                                                                                                                            | Medical           | (Check only 2 Medical Exam                                                                                                                                 | iner: On the basis of examina<br>and manner stated.                                           | ition and/or investiga                   | ation, in my opin                 | nion, death occurr                   |                                      |                                 |                                                    |
|                            | To with To Com                                                                                                                                                                                                                                                      | Σ                 | 29b. Signature and title of certifier                                                                                                                      |                                                                                               |                                          | 29c. License n                    |                                      |                                      | d. Date signed (Monti           |                                                    |
| ,                          | (15)                                                                                                                                                                                                                                                                |                   | 30. Name and address of person who o                                                                                                                       | completed cause of seath @er                                                                  | n 23a) (Type: Print)                     | 4 . ^                             | 7021                                 | 41                                   | . Jews                          | 20912<br>a Pa K, MD                                |
|                            | El.                                                                                                                                                                                                                                                                 |                   | Janna                                                                                                                                                      | completed cause of death them a Lachtchi                                                      | nina,                                    | M.D.                              | 7600 C                               | commit i                             | V CYON                          | a Palk, MD                                         |
| 1 and                      | Sta<br>Registr                                                                                                                                                                                                                                                      |                   | 31. Date filed ( <i>Month, Day, Year</i> ) <b>FEB 1 5 20</b>                                                                                               | 32 Registrar's Signa                                                                          | ture Soul                                | 2                                 |                                      |                                      | ,                               | 1 ~                                                |

DHMH 17 Rev 1/2001

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician: death.

Baltimore, Maryland 21215-0036

Hospital or Attending within 24 hours after death To the Funeral Director: completely

WH-3

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only

FEB 14 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pennsylva 32. Registrar's Signature

😂 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Lee Steele Curtis 1515 February 4 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 410 Chestnut Street Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1፟☑M 2□F Yrs 81 Director 213-22-3705 08/29/1926 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 Chestnut Street 21502 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∑Yes 2 □ No 1945 – If Yes, Give ... Year or Dates: 1946 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 Divorced 1946 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) uth and Mental Hygiene. 27 is marked other than ' r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Municipality 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton Steele Beulah Marie ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ruth C. Steele / Wife 410 Chestnut Street, Cumberland, MD Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If It any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Vet Cem @ Rocky Gap 02/07/2008 4 □ Donation 5 □ Other (Specify) Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) troutten + **Physician** SUL /Medical Due to (or as consequence of): Examiner REWAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has treetor, page 2 s autopsy performed? 1 Yes 2 No ROTENSON or Attending Physician: director. 25. Was case referred to medical examiner? Do 1 00 00 d Be 26. Place of Death (Check only one) examiner? Released Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours at To the Funeral C completely filled i Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31875 February 5, 2008 2+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nas Robert Welik, M.D. 904 Seton Drive, Cumberland, MD 21502 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 6 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Joseph Lawrence Sevinsky FEBRUARY 2008 13:17 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WMHS - MEMORIAL CAMPUS CUMBERLAND ALLEGANY If Under 24 Hrs Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1**™** M 2□ F 73 April 14, 1934 Director Maryland 217-28-9201 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner misst be access. 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director Frostburg Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Mill Street 21532-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. The Property of the Property o 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🕱 No Specify Be Completed by 3 N Widowed 4 Divorced conflict 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mill room 8 tire manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Everett Sevinsky Minnie Seib ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Maryland daughter Frostburg Karen Stair 105 Victoria Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 □ Cremation 3 □ Removal from State February 09, 2008 Frostburg 4 Donation 5 Dother (Specify) Frostburg Memorial Park Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ROBABLE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and use as the burial-tra Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day 5 ☐ Other (specify) 1 Yes 2 No detached 9□ Unknown 9 🗀 Unknown is been signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate **2** or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1⊠Yes 2⊟ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 1 Natural 5 Pending investigation death. 2K Accident 2/4/08 13:35 1 ☐ Yes 2 ☑ No after death FELL ON ICE the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

STREET 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 15 MILL ST., FROSTBURG, MD To the Hospital

within 24 hours a

To the Funeral I

completely filled Hospital Medical 29a. Certifier 15 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 6/1VA D33280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 KENT AVENUE, SUITE 101, CUMBERLAND, MD 21502 GUPTA, SUNIL K., M.D., 31. Date filed (Month, Day, Year) 37/Registrar's Signature State FEB 0 8 2008 Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

|                                |                                                                                                                                                                                                                                                   |                | For                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | State of Ma                                      | ryland / l                     | •                                |                |                         | d Mental Hy                                | giene                               |                       |                                 |
|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------|----------------------------------|----------------|-------------------------|--------------------------------------------|-------------------------------------|-----------------------|---------------------------------|
|                                |                                                                                                                                                                                                                                                   |                | State<br>Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                  |                                | Certific                         | ate of l       | Death                   |                                            | Reg. No. 🤈                          | 008                   | 06078                           |
|                                | Physicia                                                                                                                                                                                                                                          | an             | <ol> <li>Decedent's Name (First, Middle, Last,</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                  |                                |                                  |                |                         | Date of De    Month                        | eath [                              | Year                  | 3. Time of Death                |
|                                | /Medic                                                                                                                                                                                                                                            |                | Jane Tidl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                  | Schaub                         |                                  |                |                         | Februa                                     | ary 7                               | 2008                  | 7:00 P <sup>M</sup>             |
|                                | Examin                                                                                                                                                                                                                                            | er             | 4a. Facility Name (If not institution, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | street and number)                               |                                |                                  |                | Location of De          |                                            |                                     | nty of Death          |                                 |
|                                | B                                                                                                                                                                                                                                                 |                | 7837 C Street  5. Social Security Number 6. Securit | 7 Age                                            | (In yrs. last bi               |                                  |                | eake Be                 |                                            |                                     | lvert                 | lace (State or Foreign          |
|                                | Funeral Director                                                                                                                                                                                                                                  |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | М 2[ <b>X</b> F                                  | 51                             | Yrs. Mon                         |                |                         | lin. (Month, Da                            | rth<br>ay, Yea <i>r)</i><br>19 1956 | Coun                  |                                 |
|                                |                                                                                                                                                                                                                                                   |                | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                  |                                |                                  |                | J                       |                                            |                                     | 1                     |                                 |
|                                | ırylan<br>show                                                                                                                                                                                                                                    | _              | 10a. State 10b. County                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                  | 10c. City, Tov                 | wn or Location                   |                |                         |                                            |                                     | 1                     | 0d. Inside City Limits          |
|                                | ne Ma<br>8a-f s<br>ptifie                                                                                                                                                                                                                         | Director       | MD Calve                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | t                                                | Che                            | sapeak                           |                | h                       |                                            |                                     |                       | 1 X Yes 2 □ No                  |
|                                | with th                                                                                                                                                                                                                                           | ä              | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                  |                                | 101                              | . Zip Code     | 0                       |                                            | 10g. Citizen o                      | _                     |                                 |
|                                | eath                                                                                                                                                                                                                                              | Funeral        | 7837 C Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 12. Was Decedent E                               | ver in II S                    | 13 Was D                         | 2073           |                         | /Specify Ves or N                          |                                     | ed Sta                |                                 |
|                                | fter d                                                                                                                                                                                                                                            | Fu             | 1 Never Married 2 Married                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Armed Forces?<br>1 ☐ Yes 2 ☑ No                  |                                |                                  |                | an, Mexican, Pi         | ' (Specify Yes or No<br>uerto Rican, etc.) | В                                   | lack, White,          |                                 |
| Baltimore, Maryland 21215-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by             | 3 ☐ Widowed 4 ☐ Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | If Yes, Give Year or Dates:                      |                                | 1 □ Ye                           | s 2XINo        | Specify:                |                                            | Spe                                 | city: Wh              | nite                            |
| 2                              | 72 ho<br>natur<br>lical                                                                                                                                                                                                                           | Completed      | 15. Decedent's Edu<br>(Specify only highest grad                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                  | 168                            | a. Decedent's                    | Usual Occup    | ation<br>during most of | workina                                    | 16b. Kind of                        | Business/Inc          | dustry                          |
| 2                              | ithin<br>ne.<br>nan "                                                                                                                                                                                                                             | Jdr.           | Elementary/Secondary (0-12)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | College (1-4or 5+                                | -)                             |                                  |                | during most of          |                                            |                                     | an 1                  |                                 |
| 2                              | filed wi<br>Hygien<br>other th<br>ent, the                                                                                                                                                                                                        | ខ              | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                  |                                | trans                            | SCLTDE         | ionist/                 | Name (First, Middle                        | medi                                |                       | -                               |
| and                            | 12 should be filed v<br>n and Mental Hygie<br>1 <b>s marked other t</b><br>raumatic event, th                                                                                                                                                     | Be o           | Edward Burton                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Tidler                                           |                                |                                  |                |                         | ildine                                     | Bet                                 | •                     |                                 |
| Ž                              | should<br>and Men<br>marke                                                                                                                                                                                                                        | ᅀ              | 19a. Informant's Name/Relationship (7)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                  | 19                             | b. Mailing Add                   | ress (Street   |                         | r Rural Route Numi                         |                                     |                       | (Code)                          |
| <u>8</u>                       | and 2 s<br>ealth ar<br>n 27 Is<br>er trau                                                                                                                                                                                                         |                | Michael Bruce Scha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                  |                                | -                                |                |                         | Apt. #1                                    | -                                   |                       | 21045                           |
| ā,                             | permit. Pages 1 and 2<br>Department of Health a<br>Important: If item 27 Is<br>any Injury or other tra                                                                                                                                            |                | 20a. Method of Disposition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                  | 20b. Place                     | of Disposition<br>ery, crematory | (Name of       | 1                       | Date                                       |                                     | n - City or To        | own, State                      |
| Ë                              | Pages<br>nent of P<br>ant: If Ite                                                                                                                                                                                                                 |                | 1 ☐ Burial 2 【Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 1                              |                                  | •              |                         | 2-12-200                                   | B Alex                              | andria                | a. VA                           |
| a                              | permit. Departm Importa any Inju once,                                                                                                                                                                                                            |                | 21. Signature of Puneral Service Lice.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ee /                                             | /                              |                                  |                |                         | Rausch F                                   |                                     |                       |                                 |
| <u>m</u>                       | B L L                                                                                                                                                                                                                                             | 7              | LOTAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Jacol                                            |                                |                                  | 8325           |                         | armony La                                  |                                     |                       |                                 |
|                                |                                                                                                                                                                                                                                                   |                | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ications that caused<br>ne cause on each line    | the death. Do                  | not enter the                    | mode of dyir   | ng, such as car         | diac or respiratory                        | arrest,                             |                       | Approximate<br>Interval Between |
| E                              | Physician                                                                                                                                                                                                                                         |                | Immediate Cause (Final disease or condition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Breast                                           | Cance                          | er                               |                |                         |                                            |                                     |                       | Onset and Death 7 months        |
|                                | /Medical<br>Examiner                                                                                                                                                                                                                              |                | resulting in death)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Due to (or as a                                  | consequence                    | e of):                           | *              |                         |                                            |                                     |                       |                                 |
|                                | _xao.                                                                                                                                                                                                                                             | <u>.</u>       | Sequentially list conditions,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | b<br>Due to (or as a                             | consequence                    | e of).                           |                |                         |                                            |                                     |                       |                                 |
|                                | nsit                                                                                                                                                                                                                                              | nin            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                  |                                | J 5.7.                           |                |                         |                                            |                                     |                       |                                 |
| Ć,                             | cate be executed<br>physician and<br>the burial-transit                                                                                                                                                                                           | Examiner       | that initiated events<br>resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | c<br>Due to (or as a                             | consequence                    | e of):                           |                |                         |                                            |                                     |                       |                                 |
| 8760                           | te be<br>ysicia<br>e bur                                                                                                                                                                                                                          | dical          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | d                                                |                                |                                  |                |                         |                                            |                                     |                       |                                 |
| 9                              | rtifica<br>ng ph<br>as th                                                                                                                                                                                                                         | /ledi          | IS SERVICE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                  |                                |                                  |                |                         |                                            |                                     |                       |                                 |
| Š                              | The law requires that the death certific<br>tte has been signed by the attending p<br>bage 2 should be detached for use as f                                                                                                                      | Physician/Med  | 230. Was decedent pregnant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 23c. If yes, outcome p<br>1 ☐ Live birth         |                                | th 3□Ecto                        | oic pregnanc   | у                       |                                            |                                     | Date of deliv         | ,                               |
| O. B                           | e dea<br>the at<br>ned fo                                                                                                                                                                                                                         | sici           | in the past 12 months?<br>1 ☐ Yes 2 █ No<br>9 ☐ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4□Pregnant at<br>9□Unknown                       | time of death                  |                                  | er (specify)   |                         |                                            |                                     | MOITH                 | Day Year                        |
| P.0                            | that the de<br>ned by the a<br>detached f                                                                                                                                                                                                         |                | Part II. Other significant conditions co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ntributing to death bu                           | t not resulting                | in the underly                   | ina cause aiv  | en in Part I.           | 23e. Did                                   | tobacco use c                       | ontribute to t        | he cause of death?              |
| ds,                            | signe<br>d be                                                                                                                                                                                                                                     | d by           | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>3</b>                                         | 3                              | •                                | 5 5            |                         | 1                                          | Yes 2X N                            | o 3 ☐ Prol            | bably 4 □Unknown                |
| Vital Records,                 | w requires that<br>s been signed b<br>should be deta                                                                                                                                                                                              | Completed      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                  |                                |                                  |                |                         |                                            | san 2                               | Ih Were auto          | opsy findings available         |
| Bě                             | he lav<br>e has<br>ge 2                                                                                                                                                                                                                           | ם              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                  |                                |                                  |                |                         | —   auto                                   | opsy<br>formed?<br>2 2 No           | prior to co<br>death? | impletion of cause of           |
| ā                              | i <b>lcian:</b> Th<br>certificate<br>rector, pag                                                                                                                                                                                                  |                | 25. Was case referred to medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                  |                                |                                  |                | 26 Place of             | 1 Yes Death (Check only                    |                                     | 1 ☐ Yes               | 2 □ No                          |
| >                              | Physician:<br>r this certifica<br>ral director, I                                                                                                                                                                                                 | To Be          | examiner?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Hospital:<br>1 ☐ Inpatie                         | nt 2 ☐ ER/C                    | Outpatient 3[                    | DOA Oth        | nor:                    | ng Home 5 X Res                            |                                     | Other (Speci          | fv)                             |
| ٥                              | ding Ph<br>J.<br>After thi<br>funeral                                                                                                                                                                                                             |                | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 28a. Date of Injur<br>(Month, Day                | y 28b.                         | . Time of<br>Injury              | 28c. Inju      |                         |                                            | how injury oc                       |                       |                                 |
| <u>õ</u>                       | Attending<br>r death.<br>ector: After<br>by the fune                                                                                                                                                                                              | atio           | 2 Accident investigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (monal, 2a)                                      |                                | M                                |                | Yes 2 □ No              |                                            |                                     |                       |                                 |
| Division or                    | I or Attendate death<br>Director:                                                                                                                                                                                                                 | Certification: | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 28e. Place of inju<br>building, etc              | ry - At home, i<br>. (Specify) | farm, street, fa                 | actory, office |                         |                                            | (Street and Nu<br>own, State)       | ımber or Run          | al Route Number,                |
| Ω                              | oital curs af paral D                                                                                                                                                                                                                             |                | 477.0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11. 7.11.1                                       |                                |                                  |                |                         |                                            |                                     |                       |                                 |
|                                | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hi completely filled in by the funeral director, page                                                                   | Medical        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | rsician: To the best of<br>iner: On the basis of | examination a                  |                                  |                |                         |                                            |                                     |                       |                                 |
|                                | To the within 2 To the complet                                                                                                                                                                                                                    | Med            | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | and manner sta                                   | .eu.                           |                                  | 29c. Licens    | se number               |                                            | 29d. Date sig                       | gned (Month,          | Day, Year)                      |
| L L                            | ⊢ ≤ ⊢ ŏ                                                                                                                                                                                                                                           |                | · > Harris 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | · La                                             | 1. 11                          | 10                               | D(             | 0031711                 |                                            |                                     |                       | , 2008                          |
| ,                              | 1                                                                                                                                                                                                                                                 |                | 30. Name and address of person who co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ompleted cause of de                             | eath (Item 23a                 | a) (Type, Print)                 | D(             | 7031/11                 |                                            | Lent                                | ши у                  | , 2000                          |
|                                | 1 A                                                                                                                                                                                                                                               |                | ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  |                                |                                  |                |                         |                                            |                                     |                       |                                 |

dew 10 State

301 Steeple Chase Dr. #103, Prince Frederick, MD 20678 Karenga Lemmons, M.D. 32. Registrate Signature

31. Date filed (Month, Day, Year)

FEB 1 1 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:43<sup>a</sup> M Stella Elizabeth Stabnow 9, 2008 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F 395-16-1280 Yrs. Director 84 May 26, 1923 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show at 1 ☐ Yes 2 No r than "natural", or items 23a or 28a-f st the Medital Examiner must be notified Maryland Montgomery Silver Spring Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 13605 Kushner Court 20904 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 No Specify Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary <u>Private</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna James Crowder Elonza Tavenous Turner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any Injury or other trau 13605 Kushner Court, Silver Spring, MD 20904 Richard J. Stabnow/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Feb. 10, 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia Metropolitan Crematory 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** days Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease
Due to (or as a consequence of): years Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-transit Exami and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Respiratory Failure, Pneumonia 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed' 1 Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 🙀 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Box 68760 P.0. Division or Vital Records, To the Hospital or Attendl within 24 hours after death.

To the Funeral Director: A filled in by completely

altimore, Maryland 21215-0036

State Registrar

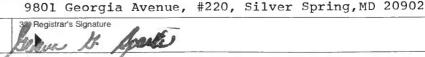
31. Date filed (Month, Day, Year)

Suresh K. Gupta, MD

29b. Signature and title of certifier

(Check only one)

FEB 11 2008



and manner stated.

30. Name and addresslof person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

d32332

29d. Date signed (Month, Day, Year)

February 9,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 **Physician** FEB. 9:00 PM 6 HELEN P. SCHUETT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY 20105 Waring Wood Way Village Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 □ M 2 🕱 F 93 Feb. 24, 1914 PENNSYLVANIA Director 133-16-6260 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ ... ary injury or other traumatic events. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐XYes 2 ☐ No Montgomery Village Director Montgomery MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20886 U.S.A. 20105 Waring Wood Way 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 2 3√2 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Petrishin Eva Slota ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type. Print) Marilyn Macht (Daughter) 20105 Waring Wood Way, Montg. Village, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 Removal from State Fern Knoll Burial Pk 2/12/08 4 □ Domation 5 □ Other (Specify) Dallas, PA 21. Sig at e of Funeral Service Lice 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** l yr Hypertensive Cardiomyobathy /Medical Due to (or as a consequence of): Examiner 2 weeks Dehydration Sequentially list conditions Examiner tany, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month for in the past 12 months?
1 ☐ Yes 2 No Day 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autonsy performed' certificate 25. Was case referred to medical 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: in 24 hours area the Funeral Director: Aft

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

20886 18550 Office Park Dr, Montgomery Village, MD

State Registra 31. Date filed (Month, Day, Year) 2008 FEB 11



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day 18 **Physician** 7:44 P M Feb 2008 Jack K. Taylor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown NMS Healthcare If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun 12, 19 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 ☑ M 2 ☐ F 62 166 - 38 - 3272Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County , or Items 23e or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Washington Hagerstown MD by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21742 USA 14014 Marsh Pike death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced \*neturel\*, Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than \* Elementary/Secondary (0-12) College (1-4or 5+) US Postal Service Mail handler 12 should be filed w h and Mental Hygier is marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Shirley R. Beil Donald B. Taylor 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ali. Pages 1 and. pertment of Health and apertant: If Item 27 is dury or other try 7 N. Allison St., Greencastle, PA 17225 Karen L. Taylor wife 20b. Place of Disposition (Name of commeter), crematory or other place)
Cumberland Valley
Crematorium Data 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 02/22/2008 Waynesboro, PA 17268 permit.
Deportra 22. Name and Address of FacilityMiller-Bowersox Funeral Home, 521 S. Washington St., Greencastle, PA 17225 21. Signature of Funeral Service Licensee ames (7 Declesses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner ementud if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intlated events resulting in death) Last Due to (or as a conseque ce of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be execut Due to (of as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year detached for Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Sursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 🕅 atural 1 ☐ Yes 2 ☐ No death. after death 2 Accident in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours a 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 052323 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) Khalid Waseem, 1126 Oral Court, Hajerstown, MD 21740 State

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician phruary Mark Wayne Terry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctor's Hospital Lanham If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Year) Days Hours Min 1 X M 2 □ F Maryland 10, 1961 Director 46 Sept. 212-90-8678 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Director Prince George's Glen Dale MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 20769 10104 Dubarry St. Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 A Divorced 3altimore, Mafyland 21215-06 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) City of Bluefield, VA Maintenance Work 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Narman D. Terry, Jr. Peggy Plyter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10104 Dubarry St. Glen Dale, MD 20769 Peggy J. Terry/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/12/2008 Alexandria, VA Metropolitan Crem. 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final irat **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executions) Due to (or as a consequence of) Examine requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) signed by the at d be detached fo 1 ☐ Yes 2 ☐ No 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 21 VNO 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral or 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

SHINVE 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MOD 60611

78118600d Lucilled, Lanham, MD.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** P, M DUUQG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death liconico CL If Vnder 24 Hrs. Hours Min. If Under 1 Year Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral D Months Days 1 M 2 □ F 9 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show fun protant: If item 27 is marked other than "natural", or items 25a or 28a-f show in protant: If item 27 is marked other than "natural be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Potomoko mma nornton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State POronoKe 4 Donation 5 Other (Specify) 2-16-08 22. Name and Advess of Facility Bennie Smith 21. Signature of Funeral Service Lis 917 W. Isabella St. Salis bury, m disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending p ası IE FEMALE use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) has been signed by the age 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy s certificate ha irector, page 2 performed 2 No funeral director, 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Inpatient After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending 4 hours after death.

-uneral Director: A
ely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02-12-2008 R. BARAL, MD SARAD 30. Name and address of person who completed cause of death (Item 29a) (Type, Print) ocomoke

Registrar

State

31. Date filed (Month, Day, Year)

FEB 13 2008

Registrar's Signature

08-01099 Me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| edford J Travers                                                                                                                                                                                                                                                                                                                                                                                                                 | 1- For State Certific                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ent of Health and Mental Hygiene<br>ate of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | e<br>Reg. No. 2008 06085                                                                                            |
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| Physician/                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | of Death 3. Time of Death                                                                                           |
| dedical Examiner                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4b. City, Town, or Location of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | uary 7, 2008 Year 1520 hrs                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Facility Name (if not institution, give street and number)     Dorchester General Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Cambridge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Dorchester                                                                                                          |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number 6. Sex 7. Age (In yrs. last bird 213–24–4383 1X M 2 F 79                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | e of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)  D. 25, 1928 Maryland                              |
| any                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | or Location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 10d. Inside City Limits                                                                                             |
| ž .                                                                                                                                                                                                                                                                                                                                                                                                                              | MD Dorchaster                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Woolford                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1 Yes 2 X No                                                                                                        |
| ith the Maryland<br>23a or 28a-f show<br>notified at once.                                                                                                                                                                                                                                                                                                                                                                       | 10e. Street and Number<br>1541 Taylors Island Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 10f. Zip Code 21677                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 10g. Citizen of What Country? USA                                                                                   |
| P B B S                                                                                                                                                                                                                                                                                                                                                                                                                          | 11. Marital Status  1 Never Married 2 Married 12. Was Decedent Ever in U.S.  Armed Forces?  1 X Yes 2 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | White, etc.                                                                                                         |
| ural", o                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 Yes 2 X No specify:  Decedent's Usual Occupation (Give kind of work don                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Эрссиу.                                                                                                             |
| 1215-0036 Land for the filed within 72 hours after dead fental Hygiene.  verent, the Medical Examiner must be Be Completed by Fun                                                                                                                                                                                                                                                                                                | Elementary/Secondary (0-12) College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | during most of working life. DO NOT use retired) pilot                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | military                                                                                                            |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than event, the Medica                                                                                                                                                                                                                                                                                                                                             | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 18.Mother's Name (First, Manual Control of the Cont |                                                                                                                     |
| 21214<br>wild be fill<br>Mental H<br>marked<br>c event, t                                                                                                                                                                                                                                                                                                                                                                        | Carl Otto Travers  19a. Informant's Name/Relationship (Type, Print )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Nellie Jon<br>Bb. Mailing Address (Street and Number or Rural Ro                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                     |
| MD 2 d 2 shoul lth and M n 27 is m aumatic                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | P. O. Box 3, Woolford, M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | D 21677                                                                                                             |
| 1. E e e e e                                                                                                                                                                                                                                                                                                                                                                                                                     | 4 Tourist 2 Committee 2 Removed from State Crema                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | of Disposition (Name of cemetery, Date atory or other place)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 20c. Location - City or Town, State                                                                                 |
| Baltimore, permit. Pages la Department of He Important: If ite injury or other ti                                                                                                                                                                                                                                                                                                                                                | 4 Donation 5 Other Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | rinity Churchyard 2/13/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                     |
| Ball<br>permit<br>Depar<br>Impor                                                                                                                                                                                                                                                                                                                                                                                                 | 21. Signaty, of Funeral Service Licensee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 22. Name and Address of Facility Thomas 700 Locust St., Cambr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | idge, MD 21613                                                                                                      |
| Physician                                                                                                                                                                                                                                                                                                                                                                                                                        | 23a. Parti. Enter the disease, or complications that caused the death. Do r failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | not enter the mode of dying, such as cardiac or respira                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | atory arrest, shock, or heart Approximate Interval Between Onset and Death                                          |
| /Medical<br>'xaminer                                                                                                                                                                                                                                                                                                                                                                                                             | Immediate Cause (Final disease or condition resulting in death)  a. Head Injuries  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Death                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                     |
| led<br>nsit<br>Fxaminer                                                                                                                                                                                                                                                                                                                                                                                                          | cause. Enter Underlying Cause (Disease or Injury that initiated Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                     |
| 60,<br>e be executed<br>ysician and<br>burial - transit                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                     |
| O,<br>e be execu<br>ysician and<br>burial - tra                                                                                                                                                                                                                                                                                                                                                                                  | UNPENDED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23d. Date of delivery                                                                                               |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Contributed by Divisional Machinal Figure 2. | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnanc 1 Live birth 4 Pregnant at time of death 1 Yes 2 No 9 Unknown 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of death 1 Representations of the pregnant at time of | y 2 Fetal death 3 Ectopic pregnancy 5 Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Month Day Year                                                                                                      |
| D. BC                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ing in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 3e. Did tobacco use contribute to the cause of death?                                                               |
| ires that the signed by                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 Yes 2 No 3 Probably 4 Unknown                                                                                     |
| Records, The law requires fireate has been sig                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?          |
| tal Rec                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 26.Place of Death (Check only or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ✓ Yes 2 No 1 ✓ Yes 2 No                                                                                             |
| Vital Rec<br>ysician: The l<br>his certificate b<br>director, page                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Othor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                     |
| Division of Vital Records, ral for a Attending Physician: The law require ra the dearth.  The forecard, After this certificate has been sited in by the funeral director, page 2 should be a stifficiality. To Be Completed                                                                                                                                                                                                      | . 27. Manner of Death 28a. Date of Injury 28t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | o. Time of Injury 28c. Injury at Work? 251 hrs 1 Yes 2 No 28d. I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Describe how injury occurred<br>enger auto auto collision                                                           |
| Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director. After templetely filled in by the funeral                                                                                                                                                                                                                                                                                       | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ocation (Street and Number or Rural Route Number, City<br>r Town, State)<br>ood Road @ Rt. 392, East New Market, MD |
| To the Hospital within 24 hours To the Funeral completely filled                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | death occurred at the time, date and place, and due to<br>r investigation, in my opinion, death occurred at the ti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | o the cause(s) and manner as stated.  me, date and place, and due to the cause(s)                                   |
| F 3 F 3                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 29c. License number O.C.M.E.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 29d. Date signed (Month, Day, Year) February 8, 2008                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 30. Name and address of person who completed cause of death (Item 23a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 3)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Donna M. Vincenti, MD Assistant Medical Examine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 201                                                                                                                 |
| Stat<br>Registra                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A Section of the sect |                                                                                                                     |
| DHMH 17 Rev 1/200                                                                                                                                                                                                                                                                                                                                                                                                                | 1 OCME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | DRIGINAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                     |

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|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------|-----------------------------|---------------------------------------|---------------------------------------------------|-----------------------------------|---------------------------------------|---------------------|-----------------------------------------------|--------------------------------|-----------------------------|
|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   | Registrar  1. Decedent's Name (First, Middle                                                                 | . Last)                                                    |                                              |                             | uncai                                 | e or bea                                          | alli                              | 2. Date of De                         | Reg. No.            |                                               |                                | of Death                    |
|                            | Physici                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                   | Helen Tarko The                                                                                              |                                                            |                                              |                             |                                       |                                                   |                                   | Februa                                | Day                 | 8, 200°                                       | 8 13                           | 48 M                        |
|                            | /Medic<br>Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                   | 4a. Facility Name (If not institution                                                                        |                                                            | er)                                          | Center                      | 4b. City                              | Town, or Loca                                     | ation of Death                    |                                       | 4c.                 | County of Dea                                 | th                             | 10                          |
|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   | Brooke Grove Rel                                                                                             | abilitation =                                              | nd No                                        | 1529                        | Sa                                    |                                                   | (J)(                              |                                       |                     | noptino.                                      | nery                           |                             |
|                            | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   | 5. Social Security Number 190–16–3670                                                                        | 6. Sex 7.<br>1 ☐ M 2](∑ F                                  | Age (In yrs.<br>84                           | last birthday)<br>Yrs.      | If Unde<br>Months                     |                                                   | Jnder 24 Hrs.<br>ours Min.        | 8. Date of Bir<br>(Month, Da<br>March |                     | C                                             | thplace (Sta<br>ountry)<br>PA  | te or Foreign               |
|                            | and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | }                 | Usual Residence of Decedent  10a. State 10b. County                                                          |                                                            | 10c. Cit                                     | y, Town or Lo               | cation                                |                                                   |                                   |                                       |                     |                                               | 10d. Inside                    | City Limits                 |
|                            | Maryl<br>1 ehc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ō                 | MD Montg                                                                                                     | nmerv                                                      | D                                            | erwood                      |                                       |                                                   |                                   |                                       |                     |                                               | 101                            | es 2₹ No                    |
|                            | r 28a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Funeral Director  | 10e. Street and Number                                                                                       |                                                            |                                              | <del></del>                 | 10f. Zi                               | p Code                                            |                                   |                                       | 10g. Citiz          | zen of What C                                 | ountry?                        |                             |
|                            | th wit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | a D               | 16308 Jousting                                                                                               | Terrace                                                    |                                              |                             | 2                                     | 20855                                             |                                   |                                       | Uni                 | Lted St                                       | ates                           |                             |
|                            | r dea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ner               | 11. Marital Status                                                                                           | 12. Was Decede<br>Armed Force                              | es?                                          |                             | Nas Dece<br>f Yes, spe                | dent of Hispan<br>ecify Cuban, Me                 | nic Origin? (S)<br>exican, Puerto | pecify Yes or No<br>Dican, etc.)      | )-                  | <ol> <li>Race - Am-<br/>Black, Whi</li> </ol> |                                | ,                           |
| 21215-0036                 | init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland setment of Health and Mental Hygiene. Certant: if Item 27 is marked other then "natural", or Items 23s or 28s-f show njury or other traumatic event, Ite Madical Examinant Link Item calling at the set of the confined at t | þ                 | 1 ☐ Never Married 2 ☐ Married 3 ☐ StWidowed 4 ☐ Divorced                                                     | ed 1 Tes 2<br>If Yes, Give<br>Year or Date                 |                                              |                             | 1 ☐ Yes                               | 2lXNo Sp                                          | pecify:                           |                                       |                     | Specify: W                                    | hite                           |                             |
| 5-0                        | natu<br>disal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Completed         | 15. Decedent<br>(Specify only highes                                                                         | 's Education<br>t grade completed)                         |                                              | (Give                       | kind of w                             | ial Occupation<br>ork done during<br>use retired) | g most of wor                     | king                                  |                     | nd of Business                                |                                |                             |
| 12                         | within<br>ene.<br>then                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ф                 | Elementary/Secondary (0-12)                                                                                  | College (1-4                                               | or 5+)                                       |                             |                                       | rator                                             |                                   |                                       | -                   | artmen<br>icultu                              |                                |                             |
|                            | Hygie<br>other                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Be Co             | 17. Father's Name (First, Middle,                                                                            | Last)                                                      |                                              | 1                           |                                       |                                                   | Mother's Nam                      | ne (First, Middle                     |                     |                                               |                                |                             |
| lan                        | Aental<br>Aental<br>rked o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | To B              | Michael Tarko                                                                                                |                                                            |                                              |                             |                                       | 1                                                 | Mary W                            | oodmask:                              | Ĺ                   |                                               |                                |                             |
| Maryland                   | id 2 should<br>th and Men<br>27 is marke<br>traumatic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                   | 19a. Informant's Name/Relations                                                                              | nip <i>(Type, Print)</i><br>Step-<br>candson)              |                                              |                             |                                       |                                                   |                                   | ral Route Numb                        | •                   |                                               |                                |                             |
| re,                        | permit. Pages 1 and 2<br>Department of Health a<br>Important: If Item 27 ti<br>any injury or other tra<br>ance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   | 20a. Method of Disposition                                                                                   |                                                            | 1 6                                          | Place of Dispo              | sition (Na                            | me of                                             | Feb                               |                                       |                     | cation - City o                               |                                | )                           |
| Ê                          | Page<br>nent o<br>nrt: If<br>iry or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   | 1 🖾 Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (S)                                                       |                                                            | St.                                          | John I                      | Sapis                                 | metery                                            | 200                               |                                       | Uni                 | Lontown                                       | , PA                           |                             |
| Baltimore,                 | Departm<br>Departm<br>Importa<br>any nju                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1                 | 21. Signature of Funeral Service                                                                             | icensee                                                    | 2                                            | 22                          | . Name a                              | nd Address of                                     |                                   | Vol Fun                               | eral                | Home                                          |                                |                             |
| <u>m</u>                   | Dep my dem                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                   | 1 resto                                                                                                      | 7- ASWOT                                                   | <u> </u>                                     | 10                          | ) Eas                                 | t Deer                                            | Park 1                            | Drive_Ga                              | aithe               |                                               |                                |                             |
| 1                          | Pnysician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1                 | 23a Part1. Enter ne disease of<br>shock, or he in failure. List<br>Imme te se (Final<br>disease or condition | complications that cau<br>only one cause on eac<br>aa      | sed the deat<br>h line.                      | h. Do not ent               | ~                                     | de of dying, su                                   |                                   | or respiratory a                      | rrest,              |                                               | Approxi<br>Interval<br>Onset a | mate<br>Between<br>nd Death |
|                            | /Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                   | resulting in death)                                                                                          | × ×                                                        | as a conseq                                  |                             |                                       |                                                   |                                   |                                       |                     |                                               | 200                            | Hac                         |
|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <u>.</u>          | Sequentially list conditions, if any, leading to immediate                                                   | b. Due to (or                                              | as a conseq                                  | uer(se of):                 |                                       |                                                   | 11100000                          |                                       |                     |                                               | m 1                            | 1005                        |
|                            | uted<br>J<br>ansit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Examiner          | cause. Enter Underlying Cause (Disease or injury that initiated events                                       |                                                            |                                              |                             | mil.                                  | e dei                                             | nent                              | ĵa.                                   |                     |                                               | uec                            | us                          |
| oʻ                         | cate be executed<br>physician and<br>the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Exa               | resulting in death) Last                                                                                     | Due to (or                                                 | as a conseq                                  | juence of):                 | · · · · · · · · · · · · · · · · · · · |                                                   |                                   | , -                                   |                     |                                               |                                |                             |
| 8760,                      | ate be<br>nysicii<br>he bu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Cal               |                                                                                                              | d                                                          |                                              |                             |                                       |                                                   |                                   |                                       |                     |                                               |                                |                             |
| 9                          | death certificate be executed<br>e attending physician and<br>id for use as the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Physician/Medical | IF FEMALE:                                                                                                   | 20. 11                                                     |                                              |                             |                                       |                                                   |                                   |                                       |                     |                                               | 1                              |                             |
| Вох                        | eath certific<br>attending p<br>I for use as I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | lan/              | 23b. Was decedent pregnant in the past 12 months?                                                            |                                                            | me of pregna<br>n 2  Feta<br>nt at time of c | ıldeath 3□                  | Ectopic                               | pregnancy                                         |                                   |                                       | 1                   | 23d. Date of de<br>Month                      | livery<br>Day                  | Year                        |
| o.                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | yslo              | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                                                                                | 9□ Unknow                                                  |                                              | ieam 5                      | J Other (s                            | pacity)                                           |                                   |                                       |                     |                                               |                                |                             |
| ۵.                         | es tha<br>gned<br>be de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Ď.                | Part II. Other significant condition                                                                         | ens contributing to deal                                   | th but not res                               | sulting in the u            | nderlying                             | cause given in                                    | Part I.                           | 1                                     | tobacco u<br>Yes 2[ | use contribute                                |                                | of death?                   |
| Š                          | w requir<br>been si<br>should                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | etec              |                                                                                                              |                                                            |                                              |                             |                                       |                                                   |                                   | 24a. Was                              |                     |                                               | utoney findi                   | ngs available               |
| l Re                       | The<br>ate h                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Completed         |                                                                                                              |                                                            |                                              |                             |                                       |                                                   |                                   | auto                                  |                     | prior to<br>death?<br>1 □ Ye                  | completion                     | of cause of                 |
| /ita                       | Physicien: 1<br>this certifical<br>ral director, p                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Be                | 25. Was case referred to medical examiner?                                                                   |                                                            |                                              |                             |                                       | 1                                                 |                                   | th (Check only                        |                     |                                               |                                |                             |
| <b>f</b>                   | Physi<br>this c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ၉                 | 1 ☐ Yes 2 No  27. Manner of Death                                                                            | Hospital: 1 ☐ Inp                                          |                                              | ER/Outpatier<br>28b. Time o |                                       |                                                   | Nursing H                         | ome 5 Res                             |                     |                                               | ecify)                         |                             |
| O                          | ding<br>h.<br>After<br>fune                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | tlon              | 1 Natural 5 Pendir<br>2 Accident investig                                                                    | 9                                                          | Day Year)                                    | Injury                      | м                                     | 28c. Injury at<br>Work?<br>1 ☐ Yes                | 2 🗆 No                            | 20d. Describe                         | now injui           | y occurred                                    |                                |                             |
| Division of Vital Records, | f or Attending<br>after death.<br>Director: After<br>I in by the fune                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Certification;    | 3 Suicide 6 Could 4 Homicide determ                                                                          | not be 28e. Place of                                       | Injury - At h<br>, etc. <i>(Speci</i>        | ome, farm, str<br>fy)       | eet, facio                            | ry, office                                        |                                   | 28f. Location<br>City or To           |                     |                                               | Rural Route                    | Number,                     |
| 7                          | To the Hospital or At<br>within 24 hours after of<br>To the Funeral Direct<br>completely filled in by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | edical C          |                                                                                                              | g Physician: To the b<br>Examiner: On the bas<br>and manne | is of examina                                |                             |                                       |                                                   |                                   |                                       |                     |                                               |                                | se(s)                       |
|                            | To the within 2 To the complet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Mec               | 29b. Signature and title of certifie                                                                         |                                                            | , 3141 <del>5</del> 4.                       |                             | 2                                     | Эс. License ли                                    | mber                              |                                       | 29d. Dat            | te signed (Mor                                | nth, Day, Yes                  | ar)                         |
| )                          | 2 (10)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                   | Kom                                                                                                          | - STAFF                                                    | PHYCIZ                                       | JAL)                        | '                                     | D42                                               | 046                               |                                       | For                 | ruani                                         | 8,2                            | 800                         |
|                            | 3 (16)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                   | 30. Name and address of person                                                                               |                                                            |                                              |                             | Print)                                | 0                                                 |                                   | rely Sp                               |                     |                                               |                                | 4 - 0                       |
| _                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   | Grace Brooke Hul                                                                                             | tran, U.D.                                                 | 18100                                        | Slade                       | Sch                                   | rool Ko                                           | ad Da                             | rly Sp                                | ring                | , Mar                                         | ylava                          | (70800                      |
|                            | Sta<br>Regist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                   | 31. Date filed (Month, Day, Year)                                                                            | 2008 32 Reg                                                | pistrar's Signa                              | ature                       | self)                                 |                                                   |                                   |                                       |                     |                                               | 7                              |                             |

State of Maryland / Department of Health and Mental Hygiene

1- State AMEND#5, 10b, 19b, perFH2/13/08, DFS, McOccertificate of Death 2. Date of Death Torres Feb.6,2008 12:05aM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 8141 Bayou Bend Blvd. Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/01/1950 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 57 Honduras 10c. City. Town or Location 10d. Inside City Limits Laurel 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? USA 8141 Bayou Bend Blvd. 20724 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 No Specify: Honduren Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

Information Analyst

Gate of Heaven

18. Mother's Name (First, Middle, Maiden Surname) Ana Lila Marcia

Bianca Torres/Daughter

192 192122Adgreasyrgang Northern Auchtoura Hindrochin or Towa Size Tia 60de) 23222 Grayline Terrace Ashburn, Va. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State

2/09/2008

PHTETPAdor RTNALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md 20910

Respiratory failure Due to (or as a consequence of): Cardiac failure Due to (or as a consequence of):

3 days

1hr

Insurance Co.

Silver Spring, Md.

Endometrial Cancer 6 mo.

Due to (or as a consequence of):

Uterine Cancer

year

IF FFMALE:

Completed

Be

2

Certification:

Medical

has

After

death.

To the Hospital o within 24 hours aft To the Funeral Di

after death

23b. Was decedent pregnant in the past 12 months?

9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 ☐ Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

23d. Date of delivery Day Month

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

26. Place of Death (Check only one)

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? Yes 2 1 No 1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 Yes 2No

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 Thomicide

29a. Certifier

5 ☐ Pending investigation 6 ☐ Could not be

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 Yes 2 No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier

29c. License number D0051774 29d. Date signed (Month, Day, Year) Feb.8,2008

30. Name and address of person who completed cause of death (item 26a) (Type, Print)

Margaret Alexander MD 9100 Old 9100 Old Georgetown Rd. Bethesda, Md 20814

State Registrar

31. Date filed (Month, Day, Year) 2 2008



and manner stated.



Division or Vital Records.

|            |                                                                                                                                                                                                                                                                                                   |                  | Pleas                                                                              | e Type or Prin<br>State of Ma                         |              |                                |                              |                       |                                 |                        | •                          |                                                        | egible.                     |                                                    |  |
|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------|-------------------------------------------------------|--------------|--------------------------------|------------------------------|-----------------------|---------------------------------|------------------------|----------------------------|--------------------------------------------------------|-----------------------------|----------------------------------------------------|--|
|            |                                                                                                                                                                                                                                                                                                   |                  | For<br>State                                                                       |                                                       |              |                                | tificate                     |                       |                                 | iu iviei               |                            | eg. No. 🤈                                              | nns                         | 06088                                              |  |
| e.         | 7 5 5                                                                                                                                                                                                                                                                                             |                  | 1. Decedent's Name (First, Middle,                                                 | - <b>nys.</b>                                         | 8            |                                |                              |                       |                                 |                        | Date of Deat               | th                                                     | <u> </u>                    | 3. Time of Death                                   |  |
|            | Physicia<br>/Medic                                                                                                                                                                                                                                                                                | _                | Bernice Thom                                                                       | as                                                    |              |                                |                              |                       |                                 |                        | Month<br><b>ebruar</b>     | y 8,2                                                  | 2008                        | <b>2328</b> M                                      |  |
|            | Examin                                                                                                                                                                                                                                                                                            |                  | 4a. Facility Name (If not institution,                                             |                                                       | _            |                                |                              |                       | Location of [                   | Death                  |                            | 3-3-3                                                  | unty of Deat                |                                                    |  |
|            |                                                                                                                                                                                                                                                                                                   |                  | Washington Adve                                                                    |                                                       |              | ışt birthday)                  | Tako                         |                       | Park If Under 24                | Hrs. 8                 | Date of Birth              |                                                        | ntgome                      | Ty hplace (State or Foreign                        |  |
| 83         | Funeral<br>Director                                                                                                                                                                                                                                                                               |                  | 5. Social Security Number 251–46–9585                                              | 1 M 2 m F 8                                           |              | Yrs.                           |                              | Days                  |                                 | Min. O                 | (Month Day,<br>ct 26,      | 1927                                                   | Sou                         | th Carolina                                        |  |
|            |                                                                                                                                                                                                                                                                                                   |                  | Usual Residence of Decedent                                                        |                                                       |              |                                |                              |                       |                                 |                        |                            |                                                        |                             |                                                    |  |
|            | arylan<br>show<br>d at                                                                                                                                                                                                                                                                            | _                | 10a. State 10b. County                                                             |                                                       | ,            | Town or Loc                    |                              |                       |                                 |                        |                            |                                                        |                             | 10d. Inside City Limits 1 → Yes 2 → No             |  |
|            | the M<br>28a-f<br>otifie                                                                                                                                                                                                                                                                          | ectc             | Maryland Prince  10e. Street and Number                                            | George                                                | Нуа          | ttsvi                          | 10f. Zip C                   | `odo                  |                                 |                        | 1                          | On Citizer                                             | n of What Co                |                                                    |  |
|            | aa or                                                                                                                                                                                                                                                                                             | Funeral Director | 4915 Eastern Av                                                                    | enue                                                  |              |                                | Ton Zip C                    |                       | 20782                           |                        |                            | United States                                          |                             |                                                    |  |
|            | ms 2%                                                                                                                                                                                                                                                                                             | nera             | 11. Marital Status                                                                 | 12. Was Decedent B                                    | Ever in U.S  | 6. 13. y                       | Vas Decede                   | nt of Hi              | spanic Origir<br>In, Mexican, F | n? (Specify            | Yes or No-                 | r No- 14. Race - American Indian, ) Black, White, etc. |                             |                                                    |  |
| ပ္         | or Ite                                                                                                                                                                                                                                                                                            | F                | 1 ☐ Never Married 2 ☐ Married                                                      | If Yes, Give                                          | No           |                                | Yes 2                        |                       | Specify:                        | rueno nia              | ari, etc.)                 |                                                        | pecify: B1                  |                                                    |  |
| 21215-0036 | ural",                                                                                                                                                                                                                                                                                            | d by             | 3 Nidowed 4 Divorced                                                               | Year or Dates:                                        |              |                                | lent's Usual                 |                       | Serv.                           |                        |                            |                                                        | of Business/                |                                                    |  |
| 7          | in 72<br>"nat<br>ledica                                                                                                                                                                                                                                                                           | Completed        | 15. Decedent's (Specify only highest                                               | grade completed)                                      |              | (Give life. L                  | kind of work<br>OO NOT use   | done d                | during most o                   | of working             |                            | TOD. KING                                              | Of Dusiness                 | industry                                           |  |
| 212        | y with<br>giene.<br>r thar<br>th. N                                                                                                                                                                                                                                                               | mo               | Elementary/Secondary (0-12) <b>Twe1th</b>                                          | College (1-4or 5                                      | )+)          | Domes                          | stic                         |                       |                                 |                        |                            | Priv                                                   | ate                         |                                                    |  |
| ē          | al Hyg                                                                                                                                                                                                                                                                                            | Bec              | 17. Father's Name (First, Middle, La                                               | ist)                                                  |              |                                |                              |                       |                                 |                        | irst, Middle, i            | Maiden Su                                              | ırname)                     |                                                    |  |
| yla        | ould b<br>Ment<br>arkec                                                                                                                                                                                                                                                                           | 으                | Lemuel Bethea                                                                      |                                                       |              | 1                              |                              |                       | Julia                           |                        |                            |                                                        |                             |                                                    |  |
| Maryland   | 12sh<br>shand<br>7ism<br>traum                                                                                                                                                                                                                                                                    |                  | 19a. Informant's Name/Relationship  Lachele A. Good                                |                                                       | hter         |                                |                              |                       | Dr.,C                           |                        |                            |                                                        |                             | •                                                  |  |
| e,         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                  | 20a. Method of Disposition                                                         |                                                       |              | ace of Dispo<br>emetery, cren  |                              |                       |                                 | brua                   |                            |                                                        | tion - City or              |                                                    |  |
| Baltimore, | Pages<br>ent of<br>nt: If ii                                                                                                                                                                                                                                                                      |                  | 1 ☑ Burial 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spe                          |                                                       |              | onetery, cren<br>Olivet        |                              |                       | 1                               | , 2008                 | _                          | Washi                                                  | ington                      | DC                                                 |  |
| Ħ          | mit. F<br>partm<br><b>sortar</b><br>/ Injui                                                                                                                                                                                                                                                       |                  | 21. Signature of Funeral Service Li                                                |                                                       |              |                                |                              |                       | ss of Facility                  | -                      |                            |                                                        | _                           |                                                    |  |
| ã          | Ded Imp                                                                                                                                                                                                                                                                                           |                  | Francis B.                                                                         | Hunt                                                  |              |                                |                              |                       | al Hom                          |                        |                            |                                                        | 2001                        | 1                                                  |  |
| п          |                                                                                                                                                                                                                                                                                                   |                  | 23a. Part1. Enter the disease, or o shock, or heart failure. List or               | omplications that caused<br>nly one cause on each lir | the death    | . Do not ente                  | er the mode                  | of dyin               |                                 | m 1                    |                            |                                                        |                             | Approximate<br>Interval Between<br>Onset and Death |  |
|            | Physician                                                                                                                                                                                                                                                                                         |                  | Immediate Cause (Final disease or condition resulting in death)                    | _a. UCu                                               | u            |                                | mm                           | an                    | 7                               | Eder                   | na                         |                                                        |                             | Orbot and Dodd                                     |  |
|            | /Medical<br>Examiner                                                                                                                                                                                                                                                                              |                  | resulting in death)                                                                | Due to (or as                                         | a consequ    | ence of):                      | Co                           | 1                     | /                               | dis                    | 000                        |                                                        |                             |                                                    |  |
|            |                                                                                                                                                                                                                                                                                                   | er               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as                                      | a consequ    | ence of):                      | wi                           | <i>,</i> ,,,,         | 77                              | 00/ 0                  |                            |                                                        |                             |                                                    |  |
|            | executed<br>in and<br>ial-transit                                                                                                                                                                                                                                                                 | Examiner         | cause. Enter Underlying Cause (Disease or injury that initiated events             | athe                                                  | rosc         | listo                          | 811°                         |                       | (                               |                        |                            |                                                        |                             |                                                    |  |
| Ó,         | oe executed<br>cian and<br>urial-transit                                                                                                                                                                                                                                                          | Exa              | resulting in death) Last                                                           | Due to (or as                                         | a consequ    | ence of):                      |                              |                       |                                 |                        |                            |                                                        |                             |                                                    |  |
| 876        | ate be<br>hysici<br>the bu                                                                                                                                                                                                                                                                        | lical            |                                                                                    | La. 14                                                | m            | rlivs                          | m                            | _                     |                                 |                        |                            |                                                        |                             |                                                    |  |
| Box 6876   | sertific<br>ding p                                                                                                                                                                                                                                                                                | Physician/Medica | IF FEMALE:                                                                         | 23c. If yes, outcome                                  | nf pregnar   | nev                            |                              |                       |                                 |                        |                            | 00                                                     | d Date of de                | firem.                                             |  |
| 80         | eath c<br>attend<br>for us                                                                                                                                                                                                                                                                        | cian             | 23b. Was decedent pregnant in the past 12 months?                                  | 1□Live birth<br>4□Pregnant at                         | 2 🗆 Fetal    | death 3                        | Ectopic pre<br>Other (spe    |                       | ,                               |                        |                            | 23                                                     | d. Date of de<br>Month      | Day Year                                           |  |
| O          | the d                                                                                                                                                                                                                                                                                             | ysi              | 1 ☐ Yes 2 🙀 No<br>9 ☐ Unknown                                                      | 9□Unknown                                             |              |                                | James (apre                  |                       |                                 |                        |                            |                                                        |                             |                                                    |  |
| О.         | The law requires that the death certificate be<br>ate has been signed by the attending physicia<br>bage 2 should be detached for use as the bur                                                                                                                                                   | by PI            | Part II. Other significant condition                                               | s contributing to death be                            | ut not resu  | lting in the ur                | nderlying cau                | use give              | en in Part I.                   |                        | 23e. Did to                | bacco use                                              | contribute t                | o the cause of death?                              |  |
| Records,   | equire<br>en sig<br>ould b                                                                                                                                                                                                                                                                        | ed k             |                                                                                    |                                                       |              |                                |                              |                       |                                 | _                      | 1 □ Y                      | 'es 2 <b>X</b>                                         | No 3□P                      | robably 4 Unknown                                  |  |
| 900        | law ras be                                                                                                                                                                                                                                                                                        | plet             |                                                                                    |                                                       |              |                                |                              |                       |                                 |                        | 24a. Was a<br>autop        | sy                                                     | prior to                    | utopsy findings available completion of cause of   |  |
| <u>س</u>   | : The<br>cate h                                                                                                                                                                                                                                                                                   | Completed        |                                                                                    |                                                       |              |                                |                              |                       |                                 |                        |                            | rmed?<br>2 X No                                        | death?<br>1 ☐ Yes           |                                                    |  |
| or Vital   | Physician:<br>this certificaral director, p                                                                                                                                                                                                                                                       | Be               | 25. Was case referred to medical examiner?                                         | Hospital:                                             |              |                                |                              | Oth                   | er.                             |                        | Check only o               |                                                        | _                           |                                                    |  |
| ō          | Phys<br>rthis<br>ral dil                                                                                                                                                                                                                                                                          | To               | 1 ☐ Yes 2 No  27. Manner of Death                                                  | 28a. Date of Inju                                     | iry          | ER/Outpatien<br>28b. Time of   |                              | Sc. Injur<br>Worl     | 4 □ Nurs                        |                        | 5 ∐ Resid<br>1. Describe h |                                                        | Other (Spendoccurred        | ecify)                                             |  |
| on         | Attending r death. ector: After by the fune                                                                                                                                                                                                                                                       | ition            | Vatural 5 ☐ Pending 2 ☐ Accident investiga                                         | (Month, Daj                                           | y Year)      | Injury                         | М                            |                       | k?<br>Yes 2∐No                  | 0                      |                            |                                                        |                             |                                                    |  |
| Division   | Atter                                                                                                                                                                                                                                                                                             | Certification:   | 3 ☐ Suicide 6 ☐ Could no determin                                                  |                                                       | ury - At hoi | me, farm, str                  | eet, factory,                | office                |                                 | 28f.                   | Location (S<br>City or Tow | Street and                                             | Number or F                 | Rural Route Number,                                |  |
|            | ital or<br>rs afte<br>ral Dii<br>led in                                                                                                                                                                                                                                                           | Cert             |                                                                                    |                                                       |              |                                |                              |                       |                                 |                        |                            |                                                        |                             |                                                    |  |
|            | Hosp<br>24 hou<br>Funel<br>tely fil                                                                                                                                                                                                                                                               | ical             | (Check only 2 Medical E                                                            | Physician: To the best<br>xaminer: On the basis o     | f examinat   | wledge, deatl<br>ion and/or in | n occurred a<br>vestigation, | it the tir<br>in my c | ne, date and<br>pinion, death   | place, and<br>occurred | d due to the at the time,  | cause(s) a<br>date and p                               | nd manner a<br>lace, and du | s stated.<br>se to the cause(s)                    |  |
|            | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2                                                                                                            | Medical          | one) 29b. Signature and title of certifier                                         | and manner sta                                        | a(ed.        |                                | 29c.                         | Licens                | e number                        |                        |                            | 29d. Date                                              | signed (Mon                 | th, Day, Year)                                     |  |
| <b>\</b>   | F≯Fŏ                                                                                                                                                                                                                                                                                              |                  | 1 Kilol                                                                            |                                                       |              |                                | 1                            | >10                   | 9891                            | ŕ                      |                            | 2                                                      | 11110                       | 8                                                  |  |
| 2          | (2)                                                                                                                                                                                                                                                                                               | _                | 30. Name and address of person w                                                   | ho completed cause of d                               | leath (Item  | 23a) (Type,                    | Print)                       | - 1                   | 1                               | ค                      | 01                         |                                                        | -/-                         |                                                    |  |
| 14         | (A)                                                                                                                                                                                                                                                                                               |                  | Abrahem B. 1)                                                                      | ibela 4                                               | 404          | <u> </u>                       | en he-                       | y R                   | ex k                            | Sun                    | dele                       | m)-                                                    | 208                         | 5/20737                                            |  |
| 3          | Sta<br>Registi                                                                                                                                                                                                                                                                                    |                  | 31. Date filed (Month, Day, Year) FEB 1 5 2008                                     | 32, Registr                                           | ar's Signat  | ture                           | -                            | ſ                     |                                 |                        |                            |                                                        |                             |                                                    |  |
|            | negisti                                                                                                                                                                                                                                                                                           | GII              | LEG TO COOL                                                                        | Blattone 1                                            | CP A         | THE REAL PROPERTY.             |                              |                       |                                 |                        |                            |                                                        |                             |                                                    |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12:15 a M Darlene Joyce Tyson February 8, 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Hospital of Cecil County Cecil Elkton 8. Date of Birth (Month, Day, Ye July 19, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Year) Months Days Hours 1 □ M 2 🖾 F 218-46-5689 60 1947 Maryland Director Usual Besidence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County tems 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Port Deposit Cecil Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21904 9 Brenda Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Married , o. 1 ☐ Yes 2 🔀 No Specify: 2 White 3 Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Dept. Social Services Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other thar Intake Worker Essex, Maryland Two Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel A. Griffin Mildred Stevens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is 9 Brenda Street, Port Deposit, Maryland 21904 Ernest L. Tyson (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 02/09/08 West Chester, Pennsylvania 4 Donation 5 Dother (Specify) R.A. Ferris & Co., Inc. 21. Signature of Funeral Service License 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a nonsectionne of Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 3 Probably 4 □Unknown 1 ☐ Yes 21110 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Yes 2 -100 Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Thpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year) FEB 1

timore, Maryland 21215-0036

ivision or Vital Records, P.O. Box 68760

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 per fh, 8876, 02/26/08dhb of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BERTHA PAULINE TOWNLEY FEBRUARY 03 2008 012:55- P\ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 366 CONGRESS AVENUE, APT HARFORD HAVRE DE GRACE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Hours 1 □ M 2 🗙 F FEB 29, 193-30-8632 71 1936 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No CECIL PORT DEPOSIT MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 RACE STREET 21904 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2X No f Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify Specify: BTACK If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING 10 VA HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CARL MORTON BROWN BERTHA IOLA JONES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSALYN TOWNLEY / DAUGHTER 441 BATTERY DRIVE, HAVRE DE GRACE, MARYLAND 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BERKLEY CEMETERY 02/09/08 DARLINGTON, MARYLAND 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, MARYLAND 21. Signature of Funeral Service Licensee Lisa Scott - Coleman per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last eneprovasus Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 Yes 2 No Month Day 5 Other (specify)

**Physician** /Medical Examiner

certificate be executed

Box 68760

P.O.

Records,

Viital

Division or

or Attending Physician:

the Hospital

within 24

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f sh notified

rai", or items 23a or Examiner must be r

"natura!"

than

other

<u>• = 6</u>

Department o Important; If any injury or

other traumatic event, the Medical

Completed by Funeral

Be

ပ

death

filed within 72 hours after

Pages 1 and 2 should be f nent of Health and Mental I

altimore, Maryland 21215-0036

Examine Physician/Medical

the burial-tran physician as use for ed by the a detached f signed by 2 should be has t page funeral director, 24 hours after death e Funeral Director: in by

Completed by

Be

P

Certification:

Medical

IF FEMALE 23b. Was decedent pregnant

9 Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury

24a. Was an autopsy performed 1□ Yes 2□ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes

2 No

25. Was case referred to medical 20 No 1 ☐ Yes 27. Januar of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 ☐ Pending

(Month, Day Year) investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 28b. Time of 28c. Injury at Work? Injury

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No 3 ☐ Probably

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

6 □Other (Specify)

30. Name and address of person who completed

MO 31. Date filed (Month, Day, Year) FEB 5 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2 State of Maryland / Department of Health and Mental Hygiene dr., g8/6,02/26/08dhb
Certificate of Death

Reg. No. 1 - For State Registrar Reg. No. 2008-06091 2. Date of Death 02/13/2008 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:00 a<sup>M</sup> ISABELLE LAVERNA THOMPSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Y May 31, 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min. 1 ☐ M 2 ☐ F 1921 Director 215-12-2107 86 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at MD Allegany Cumberland 1 ☐Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 22 Arch Street items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 11 Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☐ 📉 Saltimore, Maryland 21215-0036 þ 3 Midowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: If Item 27 is marked other the 12 Celanese laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leora Coughneour Peterson Peter Peterson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 Cumberland Doris Peterson sister 24 Arch Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Deurial 2 ☐ Cremation 3 ☐ Removal from State 2/17/2008 MD Sunset Memorial Park Cumberland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm ate Cause (Final Acure **Physician** DA45 LENA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner )rosepsis DAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for 1 in the past 12 months?
1 Yes 2 XVo
9 Unknown Month Day 4 ☐ Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 417WanaC 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2: autopsy performed 2 No certificate 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**∑**No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Attending 5 ☐ Pending investigation 1XNatural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 14,2008 D54411 30. Nav e and address of very on who completed cause of death (Item 23a) (Type, Print)

State Registrar BEVERLY M. CALKINS,

M.D.

32. Registrar's Signature

DHMH 17 Rev 1/2001

500 MEMORIAL AVE., CUMBERLAND, MD 21502

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| Department of Health and Mental Hygiene. Important: friems 23a or 28a-f show Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Oc. 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| director, page 2 should be detached for use as                                                                                                                                                                                                    | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  Part II. Other significant condi  25. Was case referred to medic examiner?  1 □ Yes 2 ☒ No  27. Manner of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 ☐Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown  tions contributing to death but r  Hospital: 1 ☑ Inpatient 28a. Date of Injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Petal death 3 [ne of death 5 [not resulting in the upper second content of the co | Other (special underlying cause and a pool of the pool | 26. Place Other: Injury at Work?                                                                               | e of Death (Cursing Home                                        | 1  Y  24a. Was a autop: perfor 1 Yes  Check only or 5  Resid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Month bacco use contribut es 2 No 3 an sy med? 24b. 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Yes 2 ☒ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |
| uneral director, page 2 should be detached for use as                                                                                                                                                                                             | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  Part II. Other significant condi  25. Was case referred to medic examiner?  1 □ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 □ Pend inves                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1 ☐Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown  tlons contributing to death but re  tal  Hospital: 28a. Date of Injury (Month, Day Y                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Petal death 3 [ ne of death 5 [ not resulting in the use of the second s | Other (special content of special content of specia | 26. Place Other: 4   Nu Injury at Work? 1   Yes 2                                                              | e of Death (Cursing Home 28c                                    | 1  Y  24a. Was a autop: perfor 1 Yes  Check only or 5 Resid.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Month bacco use contribut es 2 No 3 an 24b. 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Yes 2 X No  Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |
| uneral director, page 2 should be detached for use as                                                                                                                                                                                             | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  Part II. Other significant condi  25. Was case referred to medic examiner?  1 □ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 □ Pend 2 □ Accident 3 □ Suicide 6 □ Coulc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1 ☐Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown  tions contributing to death but r  the spital: 1 ☑ Inpatient 28a. Date of Injury (Month, Day Y                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Petal death 3 [ ne of death 5 [ not resulting in the use of the second s | Other (special content of special content of specia | 26. 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| uneral director, page 2 should be detached for use as                                                                                                                                                                                             | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?  1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1 ☐Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown  tions contributing to death but r  tions contributing to death but r  28a. Date of Injury (Month, Day Y building, etc. (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Petal death 35 ine of death 55 ine of death 55 ine of resulting in the understanding in the u | other (special underlying cause and 3 DOA of 28c M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 26. Place Other: Unique at Work?  1 Yes 2                                                                      | e of Death (Cursing Home 28c                                    | 1 Y  24a. Was a autop: perfor 1 Yes  Check only or 5 Resid  Describe h  Location (S City or Tow                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Month bacco use contribut es 2 No 3 an 24b. Were prior deat 2 No 1  ence 6 Other (3 ow injury occurred  treet and Number on, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Day Year  te to the cause of death?  Probably 4 \( \text{QUnknow} \)  re autopsy findings availabre to completion of cause of the?  Yes 2 \( \text{No} \)  Specify)  or Rural Route Number,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |
| uneral director, page 2 should be detached for use as                                                                                                                                                                                             | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant condi  25. Was case referred to medic examiner?  1   Yes   2   No   No    27. Manner of Death 1   Natural   5   Pend inves   Pend    tions contributing to death but respiral:  Hospital:  28a. Date of Injury (Month, Day Y building, etc. (  28e. Place of injury building, etc. (  28d. Date of Injury (Month, Day Y building) etc. (  28d. Place of injury building, etc. (  28d. Place of injury building, etc. (  28d. Place of injury building, etc. (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Petal death 3 [ ne of death 5 [ not resulting in the understand the content of th | other (special anderlying cause and anderlying cause a | 26. 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| uneral director, page 2 should be detached for use as                                                                                                                                                                                             | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant condi  25. Was case referred to medic examiner?  1   Yes 2   No    27. Manner of Death  1   Natural   5   Pend investigation of the could detern of the could detern of the could detern only one)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | tions contributing to death but respectively.  Hospital: 1 Maintain Inpatient  28a. Date of Injury (Month, Day Y building, etc.)  28e. Place of Injury building, etc. (Maintain Inpatient)  28e. Place of Injury building, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Petal death 3 [ ne of death 5 [ not resulting in the understand the content of th | ent 3 DOA of 28c M 28c treet, factory, o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 26. Place 26. Place Other: 4 Nu Injury at Work? 1 Yes 2                                                        | e of Death (Cursing Home 28c                                    | 1 Y  24a. 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I due to the cause(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |
| uneral director, page 2 should be detached for use as                                                                                                                                                                                             | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant condi  25. Was case referred to medic examiner?  1   Yes   2   No    27. Manner of Death  1   Natural   5   Pend   P | 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown  tions contributing to death but r  tions contributing to death but r  28a Date of Injury (Month, Day Y building, etc. (  ting Physician: To the best of rall Examiner: On the basis of examiner states of the contribution of the contribution of the basis of examiner of t | Petal death 35 ne of death 55 ne of death 55 ne of resulting in the control of th | other (special anderlying cause and  | 26. Place 26. Place Other: 4 Nu Injury at Work? 1 Yes 2 Diffice the time, date an my opinion, decisions number | e of Death (Cursing Home 28c No 28f and place, and ath occurred | 1 Y  24a. Was a autop: perfor 1 Yes  Check only or 5 Resid  Describe h  Location (S  City or Tow  d due to the cat the time, of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Month bacco use contribut es 2 No 3 and 24b. Were prior prio | Day Year  te to the cause of death?  Probably 4 AUnknow e autopsy findings availabre to completion of cause of the second state of the second stat |  |  |  |
| uneral director, page 2 should be detached for use as                                                                                                                                                                                             | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant condi  25. Was case referred to medic examiner?  1   Yes   2   No   No    27. Manner of Death   1   Natural   5   Pend investigation of the past of  | tions contributing to death but respectively.  Hospital: 1 Main Impatient  28a. Date of Injury (Month, Day Y building, etc.)  28e. Place of Injury building, etc. (Main Impatient)  28e. Place of Injury building, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Petal death 3 [ne of death 5 []  and resulting in the understand the period of the per | other (special and error special and error speci | 26. 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Date signed (No 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Day Year  te to the cause of death? 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If due to the cause(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |
| Inis certificate has been signed by the attending all director, page 2 should be detached for use as                                                                                                                                              | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant condi  25. Was case referred to medic examiner?  1   Yes   2   No    27. Manner of Death  1   Natural   5   Pend   P | tions contributing to death but respectively.  Hospital: 1 Main Impatient  28a. Date of Injury (Month, Day Y building, etc.)  28e. Place of Injury building, etc. (Main Impatient)  28e. Place of Injury building, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Petal death 3 [ne of death 5 []  and resulting in the understand the period of the per | other (special and error special and error speci | 26. Place Other: 4 Nt. Injury at Work? 1 Yes 2 Diffice the time, date an my opinion, decicense number          | e of Death (Cursing Home 28c No 28f and place, and the occurred | 1 Y  24a. Was a autop: performer former form | Month bacco use contribut es 2 No 3 and 24b. Were prior prio | Day Year  te to the cause of death? Probably 4 Qunknov re autopsy findings availate to completion of cause of the? Yes 2 No  Specify)  Pr Rural Route Number, er as stated. If due to the cause(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |

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|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------|-----------|--------------------------------------------|--------------------------------|---------------------------------|--------------------------|----------------------------------------|---------------------------------------------------------------------------|--|--|
|                | Physici<br>/Medie                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Decedent's Name (First, Middle ROSHALL VEREEN                                                                                                                                                                                                         | , Last)                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           |                      |           |                                            |                                | 2. Date of D<br>Month<br>02     | eath<br>Day              | 2008                                   |                                                                           |  |  |
|                | Examir                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution PRINCE GEORGES                                                                                                                                                                                                  |                                                     | mber)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                           | 4b. City, T          |           | Location of                                | Death                          |                                 | 1                        | County of D                            | eath<br>GEORGES                                                           |  |  |
|                | <ul><li>Funeral Director</li></ul>                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 5. Social Security Number 252–52–1978                                                                                                                                                                                                                 | 6. Sex<br>1                                         | 7. Age (in yrs. 75                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                           | If Under 1<br>Months |           | If Under 24<br>Hours                       | Hrs.<br>Min.                   | 8. Date of 8 (Month, D<br>03/14 | rth<br>ay, Year)<br>1932 | 9. I<br>GE(                            | Birthplace (State or Foreign<br>Country)<br>DRGIA                         |  |  |
|                | Maryland -f show                                                                                                                                                                                                                         | tor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent  10a. State 10b. County MD PRINCE                                                                                                                                                                                         | GEORGES                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | y, Town or Lo                                             |                      |           |                                            |                                |                                 |                          |                                        | 10d. Inside City Limits                                                   |  |  |
|                | th with the<br>23e or 28e                                                                                                                                                                                                                | ai Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 10e. Street and Number<br>4142 BUNKER HILL                                                                                                                                                                                                            | ROAD APT                                            | .# 308                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                           | 10f. Zip 0           |           |                                            |                                |                                 | 10g. Cit                 | izen of What                           | Country?                                                                  |  |  |
| 036            | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itsm 27 le marked other than "natural", or iteme 23e or 28e-f show other treumatic event, its Modical Examinar must be notified at | by Funerai                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☒ Widowed 4 ☐ Divorced                                                                                                                                                                               | Armed Fo                                            | 2 ( <b>Ž</b> ) No<br>∕e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                           | Was Decede           |           | spanic Origii<br>n, Mexican, i<br>Specify: | n? (Spe<br>Puerto              | ecify Yes or N<br>Rican, etc.)  | 0-                       | 14. Race - A<br>Black, W<br>Specify: B |                                                                           |  |  |
| 21215-0036     | d within 72 ho<br>giene.<br>ir than "natui<br>ire Modical                                                                                                                                                                                | Completed by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 15. Decedent<br>(Specify only highes<br>Elementary/Secondary (0·12)<br>0                                                                                                                                                                              |                                                     | -4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (Give                                                     | DO NOT use           | done d    | during most o                              | f worki                        | ng                              |                          | ind of Busine                          | ss/Industry                                                               |  |  |
| Maryland 2     | should be filed<br>nd Mental Hyg<br>marked othe<br>umatic event,                                                                                                                                                                         | To Be C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 17. Father's Name (First, Middle, I<br>HALL VEREEN                                                                                                                                                                                                    | Last)                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN |                      |           |                                            |                                |                                 |                          |                                        |                                                                           |  |  |
| ore, Mar       | es 1 and 2 sho<br>of Health and<br>If itsm 27 le ma<br>or other treums                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 19a. Informant's Name/Relationsh SANDRA FULLER/D 20a. Method of Disposition 1 Deural 2 Ki Cremation                                                                                                                                                   | AUGHTER                                             | AUGHTER  20b. Place of Disponentery, creft RIVERDALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                           |                      |           | AVE.                                       | TAI                            | if Route Numi<br>NEYTOW<br>Date | , MI                     |                                        |                                                                           |  |  |
| Baltimore,     | permit. Pages 1 and Department of Heali Important: If itsm 2 any injury or other once.                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | A Donation 5 Other (Specify)  RIVERDALE CREMATORY 2/12/2008 RIVERDALE, MD  21. Signature of Funeral Service Licensee  A Donation 5 Other (Specify)  22. Name and Address of Facility J.B. JENKINS FUNERAL HOME  7474 LANDOVER ROAD LANDOVER, MD 20785 |                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           |                      |           |                                            |                                |                                 |                          |                                        |                                                                           |  |  |
| jár<br>c       | Physician<br>/Medical<br>Examiner                                                                                                                                                                                                        | 23a. Part1. Enter the disease, Mr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. SEPSIS  Due to (or as a consequence of):  PNEUMONIA  b. Just (or as a consequence of):  Cause (Disease or injury that indiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of): |                                                                                                                                                                                                                                                       |                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           |                      |           |                                            |                                |                                 |                          |                                        | Approximate<br>Interval Between<br>Onset and Death                        |  |  |
| 3ox 68760,     | leath certificate be executed attending physicien and for use as the burial-transit                                                                                                                                                      | ledicai                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | d.                                                                                                                                                                                                                                                    |                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           |                      |           |                                            |                                |                                 |                          |                                        | delivery<br>Day Year                                                      |  |  |
| , P.O. Box     | The law requires that the death cer<br>tie has been signed by the attendir<br>rage 2 should be detached for use                                                                                                                          | by Physician/M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown<br>Part II. Other significant conditio                                                                                                                                                                                  | 9□ Unkno                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           | Other (spe           |           | en in Part I.                              |                                | 23e. Did                        | tobacco                  |                                        | e to the cause of death?                                                  |  |  |
| Vital Records, | law require<br>as been sig<br>2 should b                                                                                                                                                                                                 | Completed b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                       |                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           |                      |           |                                            | _                              | 24a. Wa                         |                          |                                        | Probably 4 Unknown a autopsy findings available to completion of cause of |  |  |
| /ital R        |                                                                                                                                                                                                                                          | Be Com                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 25. Was case referred to medical examiner?                                                                                                                                                                                                            | - IIi                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           |                      | 101       |                                            | f Death                        | per<br>1 ☐ Yes<br>(Check only   | ormed?<br>2 X No         | death                                  | n?<br>Yes X∐ No                                                           |  |  |
| Division of \  | To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,                                                                          | Certification: To                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 Yes 2 No  27. Manner of Death  Natural 5 Pending 2 Accident investig 3 Suicide 6 Could r                                                                                                                                                            | ation M 1 Yes 2 No                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           |                      |           |                                            | Specify) r Rural Route Number, |                                 |                          |                                        |                                                                           |  |  |
| Ď              | Hospitel or A<br>24 hours after<br>Funeral Dire                                                                                                                                                                                          | edical Certif                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (Check only 2 Medical I                                                                                                                                                                                                                               | buildi<br>g Physician: To the<br>Examiner: On the b | ng, etc. (Specification of the state of my known of examination of | y)<br>owledge, deat                                       | h occurred a         | t the tin | ne, date and<br>pinion, death              | place, a                       | City or To                      | own, State               | ) and manner                           | r as stated.                                                              |  |  |
| ł              | To the H<br>within 24<br>To the Fi<br>complete                                                                                                                                                                                           | Medi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 29b. Signature and title of certifier                                                                                                                                                                                                                 | and man                                             | ner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                           | 29c.                 |           | number                                     |                                |                                 | 29d. Da                  | ite signed (M                          | igned (Month, Day, Year)  RY 8 2008                                       |  |  |

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 1 3 2008

PATRICIA EBEN M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 9, **Physician** 12:37 pM February 2008 Humbert Richard Ventura, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 12, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 ☐ F Yrs. Pennsylvania 84 198-18-0840 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notifled at 1 ☐ Yes 2 ☐ No Director Montgomery Rockville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11410 Grayling Lane 20852 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked others any injury or other 27. 1 X Yes 2 □ No
If Yes, Give
Year or Dates: 1943-46 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No White Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Postal Service Letter Carrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amelia Fee Humbert Richard Ventura, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Jean Ventura-Marion/Daughter 11410 Grayling Lane, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 15, Feb. Gate of Heaven Cemetery 2008 Silver Spring, Maryland 4 Donation 5 Other (Specify) Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. Arteriosclerotic Heart Disease Unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its agents.) Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4☐Pregnant at time of death 2 🗆 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown Groin Infection Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 🔼 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \sum \) Nursing Home Hospital: 1 ☐ Yes 2 🔀 No 1 🔲 Inpatient 2 ☐XER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred al or Attending P after death. I Director: After t d in by the funera 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

To the Hospital within 24 hours a To the Funeral E 20+1

Division or Vital Records, P.O. Box 68760,

State Registrar

cal

(Check only

certifier

Brendan J. Carmody,

FEB 1 2 2008

31. Date filed (Month, Day, Year)

one)

29b. Signature and

DHMH 17 Rev 1/2001

and manner stated

Registrar's Signature

m.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DO 22480

8600 Old Georgetown Road, Bethesda, MD 20814

29d. Date signed (Month, Day, Year)

0

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 1<sup>Day</sup> <sup>Year</sup> 08 **Physician** 1705 Jerry Wade White /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year! Months Days Hours 1 X M 2 □ F 67 March 21,1940 Whitmer, WV Director 232-60-7396 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo WV New Creek Grant 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 26743 USA HC 72, Box 209 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours afte Department of Heath and Mental Hyglene. Inportant: If Item 27 is marked other than "natural", or I amy criptury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Carpenter & Mason Carpentry & Masonry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Glenn Olie White Matie Day 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Vivian M. White/ Wife</u> HC 72, Box 209 New Creek, WV \_26743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 18 Feb. 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens Keyser, WV 2008 22. Name and Address of Facility Smith Funeral Home 21. Signature of Funeral Service License 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MASSIVE hemorra /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 2 funeral 27. Manner of Death 1 Watural 28b. Time of 28d. Describe how injury occurred 28a Date of Injury 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division or Vital Records, or Attending Physician: ours after death.

neral Director: Af filled in by the fur **Fo the Hospital** within 24 hours a

> State Registrar

Medical

29a. Certifier

29b. Signatu.

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Seton

and manner stated

address of person who completed cause of death (Item 23a) (Type, Print)

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00/82/6

Cum berland, Mary land

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 5 30 7 M George Weatherholt 3 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Devlin Manor Nursing Home** Cumberland Allegany | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug 1, 1910 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 217 10 4203 Yrs **Director** Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23s or 28s-f show other traumatic event, the Mudical Examinar must be notified at MD Allegany Cumberland 1 Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 220 Somerville Avenue Apt. 615 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Accounting Supervisor Drug Manufacturing permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: If Item 27 le marked othe eny fluity or other traumatic event, ance. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be Seymour J. Weatherholtz Mary Susan Ours Weatherholtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 76 Forrest Dr. Fisher WV 26818 Otis Weatherholtz Jr. nephew 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Mary's Cemetery 2/15/2008 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Litensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23s 1711. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Ogset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year. 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 1 10 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 21110 1 Yes 2 NO 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D54411 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REVERLE M.D 500 MEMORIAL AVE. CLUMBERAND, MD 21502 31. Date filed (Month, Day, Year) 32. Panstrar's Signature State Registrar 2008

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:35 P **Physician** Feb 22 2008 Day Clayton Joseph Waggener /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Lusby Calvert 11517 Durango Drive if Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 7. 1497 Days 578ciat Security Sumber 7. Age (In yrs. last birthday, 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign **Funeral** July 2 1945 ar) Washington DC Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Calvert. Lusby 1 ☐ Yes 2 No Director 10e. Street and Number 11517 Durango Drive 10f. Zip Code 20657 10g. Citizen of What Country? United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 May 2 D No. 1f Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. other than "natural", or ite 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 HNo þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Element 2/Secondary (0-12) College (1-4or 5+) building maintance PG Cb. Schools 17. Father's Name (First, Middle, Last) Ben Waggoner 18. Mother's Name (First, Middle, Maiden Surname) Irene Pern mit. Pages 1 and 2 should be file partment of Health and Mental Hy portant: If item 27 Is marked oth y Injury or other traumatic event Be ပ 19a. Informant's Name/Relationship (Type. Print) Nancy Louise Waggoner- wife 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11517 Durango Drive Lusby MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Middleham Chapel Certecery Feb 27 2008 1 Burial 2 □ Cremation 3 □ Removal from State Lusby Maryland permit. Page Department o Important: If any Injury or 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Rausch Fineral Home 21. Sign turn of Euneral Service Lio 20 American Lane Lusby, MD 20657 23a. Part1. Enter the disease, of complications that shock, or heart failure. List only one cause of crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician hours /Medical Due to (or as a consequence Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and I-trans Due to (or as a consequence of): burialphysician s the burial P.O. Box 68760 Physician/Medical as IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 2 No 3 Probably 4 Donknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No certificate has 1□ Yes Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 ☐ Yes 1 | Inpatient 2 ER/Outpatient 3□ DOA this funeral dir To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Natural 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🚝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 2 7

25 OY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul V. Pamilla MD 110 Hospital Drive Suite 310 Prince Frederick MD 20678

32. Registrar's Signature

Carle 18-

2008

29c. License number

29d. Date signed (Month, Day, Year)

U

#### State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** BARRY GLENN WINT rebruary 11. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci System Perry Point VA Maryland Health Care If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 62 212-48-7081 7/6/1945 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at PERRY POINT MD Director CECIL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code BUILDING 5H CIRCLE DRIVE 21902 # EXEC USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Y Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Naryland 212/5-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Mones. UNKNOWN UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EMILY A. JONES 2 GLENN F. WINT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VAMC, PERRY POINT, MD 21902 AIMEE SAYLOR/DETAILS CLERK யி≀ NT, G Baltimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State FEBRUARY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SMITHSBURG, MD 4 □ Donation 5 □ Other (Specify) SMITHSBURG CREMATORY 21,2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, les M. K 327 W. KING ST., MARTINSBURG, WV 25402 lower 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** arcinoma /Medical Due to (or as a consequence of). Examiner hronic Obstructive tulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3X Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 29a. Certifier 🖼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

). VA Maryland 32. Refistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

(:15AM

MARYLAND

WHITE

10d. Inside City Limits

Approximate Interval Between Onset and Death

inknowr

INKNOWI

Year

Day

ebruary

toint

1 ☐ Yes 2 ☑ No

State Registrar 31. Date filed (Month)

Known

am

Care System

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Feb-15-2008 **Physician** Ray 8:00 am Edgar Waugh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Autumn Assisted Living Hagerstown If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral 1∏M 2□F Director 84 Mar-21-1923 WVa Morgan 235-32-0034 Usual Residence of Decedent filed withIn 72 hours after deeth with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ai Hygiene. I other than "natural", or items 23a or 28e-f show event, the Madical Examinar must be notified at 1 Yes 2 No Director WVa Morgan Berkeley Springs 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 338 Wilkes St. 25411 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1▼DYes 2□No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Mill Wright General Motors od 2 should be filed (th and Mentai Hygli 27 is marked other r traumatic event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thomas Warner Waugh Evaline Nora Everett ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Itsm 27 Pauline Waugh - Wife 338 Wilkes St, Berkeley Springs WV 25411 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Pege Depertment of Important: If any injury or once. \*4 Donation 5 Other (Specify)

21. Signature of Fuheral Sejfvice Licenses Greenway Cemetery 2-18-08 Berkeley Springs 22. Name and Address of Facility 36 S. Green St, Berkeley Springs WV 25411 23a. Anti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Physician one month disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner unknow Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq Examiner The law requires that the death certificate be executed attending physician and for use es the burial-trensit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No pege 2 has certificete director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 958 15 fed Line 1 ☐ Yes 2 No Medical Certification: To After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No nerel Director; A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitel or At within 24 hours after or To the Funerel Direct 4 Homicide 1/2 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier feb 19, 2008 D 44996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 20311 Lappans Road, Boonsboro, MD 21713 Zafar Malik, MD, 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Division or Vital Records, P.O. Box 68760,

|                                                                                                                                                                                                               |                | For                                                                                                          |                             | State                             | of Marylan                                                      |                              | artment of F                                   |                                       | ind Me                   | ental Hyg                            | giene                      |                               |                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------------------|-----------------------------------------------------------------|------------------------------|------------------------------------------------|---------------------------------------|--------------------------|--------------------------------------|----------------------------|-------------------------------|-----------------------------------------------|
|                                                                                                                                                                                                               |                | 1 - State<br>Registrar                                                                                       |                             |                                   |                                                                 | Ce                           | ertificate of                                  | Death                                 |                          |                                      | Reg. No.                   | 008                           | 06100                                         |
| Physicia<br>/Medic                                                                                                                                                                                            |                | 1. Decedent's Name                                                                                           | (First, Middle<br>WAD       |                                   |                                                                 |                              |                                                |                                       |                          | 2. Date of Dea<br>Month<br>FEBRUAR   | Day                        | 2008                          | 5:09 P M                                      |
| Examin                                                                                                                                                                                                        |                | 4a. Facility Name (If r                                                                                      | not institution             | , give street and n               | umber)                                                          |                              | 4b. City, Town, o                              |                                       |                          |                                      | 4c. Co                     | ounty of Death                |                                               |
|                                                                                                                                                                                                               | 25             | WASHINGTO                                                                                                    |                             | VTY HOSP                          |                                                                 | In mit in lint in afro.      | 1 1/11 1 1 11                                  | AGERST                                |                          | 8. Date of Birtl                     |                            |                               | NGTON                                         |
| Funeral<br>Director                                                                                                                                                                                           |                | 5. Social Security Nur  NONE                                                                                 |                             | 1 M 2 N F                         | 7. Age (In yrs.                                                 | Yrs.                         | Months Days                                    | Hours 2                               | Min.                     | (Month, Day<br>FEB. 6                | r, Year)                   | Cou                           | place (State or Foreign<br>ntry)<br>ARYLAND   |
| W                                                                                                                                                                                                             |                | Usual Residence of D                                                                                         | Decedent<br>10b. County     |                                   | 10c. Cit                                                        | y, Town or L                 | ocation                                        |                                       |                          |                                      |                            |                               | 10d. Inside City Limits                       |
| f sho<br>led at                                                                                                                                                                                               | ē              | MARYLAND                                                                                                     | -                           | HINGTON                           |                                                                 |                              | HAGERST                                        | POLINI                                |                          |                                      |                            |                               | 1 ☐Yes 2XNo                                   |
| r 28a<br>notif                                                                                                                                                                                                | Director       | 10e. Street and Numb                                                                                         |                             | ITHOTON                           |                                                                 |                              | 10f. Zip Code                                  | COMIN                                 |                          |                                      | 10g. Citizer               | n of What Cou                 | intry?                                        |
| 23a o<br>ist be                                                                                                                                                                                               |                | 9728 PEMI                                                                                                    | BROKE I                     | DRIVE                             |                                                                 |                              |                                                | 21740                                 |                          |                                      |                            | U.S.A                         |                                               |
| er mu                                                                                                                                                                                                         | Funeral        | 11. Marital Status                                                                                           |                             | 12. Was De<br>Armed F             |                                                                 | .S. 13                       | . Was Decedent of H<br>If Yes, specify Cub     | lispanic Orig<br>an, Mexican          | gin? (Spec<br>, Puerto F | cify Yes or No-<br>Rican, etc.)      | 14.                        | Race - Ameri<br>Black, White, | can Indian,                                   |
| ", or it<br>camin                                                                                                                                                                                             | by Fu          | 1 X Never Married 3 Widowed 4                                                                                |                             | ed 1 Tyes<br>If Yes, G<br>Year or |                                                                 |                              | 1 ☐ Yes 2 ☑ No                                 | Specify:                              |                          |                                      | Sp                         | pecify:                       | WHITE                                         |
| atural<br>caf Ex                                                                                                                                                                                              |                | 1                                                                                                            | 15. Decedent                | 's Education                      |                                                                 | 16a. Dec                     | edent's Usual Occup                            | ation                                 |                          | T                                    | 16b. Kind                  | of Business/Ir                |                                               |
| e.<br>Medi                                                                                                                                                                                                    | Completed      | (Specify Elementary/Second                                                                                   |                             | t grade completed<br>College      | )<br>(1-4or 5+)                                                 | (Giv<br>life.                | re kind of work done<br>DO NOT use retire      | during most<br>d)                     | g                        | ,                                    |                            |                               |                                               |
| ygien<br>rer th<br>t, the                                                                                                                                                                                     | S              | NONE                                                                                                         |                             |                                   |                                                                 |                              | INFAN                                          |                                       |                          |                                      |                            | INFAN                         | T                                             |
| even                                                                                                                                                                                                          | æ              | 17. Father's Name (F                                                                                         |                             | Last)                             |                                                                 |                              |                                                |                                       | (First, Middle,          |                                      | ŕ                          |                               |                                               |
| d Mei<br>marke                                                                                                                                                                                                | 욘              | BRUCE E. V                                                                                                   |                             | nin (Tyne Print)                  |                                                                 | 19h Mai                      | ling Address (Street                           |                                       |                          | IA CRUI                              |                            |                               | n Code)                                       |
| ith an                                                                                                                                                                                                        |                | BRUCE E. V                                                                                                   |                             |                                   |                                                                 |                              | B PEMBROKI                                     |                                       |                          |                                      |                            |                               |                                               |
| f Hea<br>item (                                                                                                                                                                                               |                | 20a. Method of Dispo                                                                                         | sition                      |                                   |                                                                 | Place of Dist                | position (Name of ematory or other place       | - 1                                   |                          | ate                                  |                            | tion - City or T              |                                               |
| int: If                                                                                                                                                                                                       |                | 1 🔀 Burial 2 🗆<br>4 🗆 Donatjon 5                                                                             |                             | 3 □Removal fron<br>pecify)        | n State                                                         | -                            | RO CEMETER                                     | i                                     | 2/13                     | /2008                                | BOONS                      | SBORO.                        | MARYLAND                                      |
| Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show myn injury or other traumatte event, the Medical Examiner must be notified at once. |                | 21. Signature of Fund                                                                                        | eid service                 | S 77-13                           | Τ.                                                              | Ī                            | 22. Name and Addre BAST FUNER                  | ss of Facility                        | y<br>ME                  | 7606 01                              | d Nat                      | ional                         | Pike                                          |
| 200                                                                                                                                                                                                           |                |                                                                                                              | e di                        | cations that                      | caused the deat                                                 |                              | nter the mode of dyli                          | ng, such as                           |                          | Boonsbo<br>respiratory ar            |                            | aryran                        | Approximate                                   |
| ysician                                                                                                                                                                                                       |                | Immediate Cause (Fi                                                                                          | inal                        | only one cause on                 | x trai                                                          | ne                           | Rrem                                           | alu                                   | rile                     | , 22                                 | We                         | eks                           | Interval Between<br>Onset and Death           |
| Medical<br>aminer                                                                                                                                                                                             |                | resulting in death)                                                                                          |                             | Due to                            | o (or as a conseq                                               | uence of)                    | nu av                                          | CICO X                                | 1                        | - 1                                  |                            | 188                           |                                               |
| sit                                                                                                                                                                                                           | iner           | Sequentially list condificant, leading to immoduse. Enter Underly Cause (Disease or in that initiated events | ditions,<br>nediate<br>ying | D. Due to                         | (or as a conseq                                                 | uence of):                   | 7 1                                            | 7 0.3                                 | 21_0                     |                                      |                            |                               |                                               |
| physician and<br>the burial-transit                                                                                                                                                                           | Examin         | that initiated events<br>resulting in death) La                                                              | ast                         | c. Lui                            | (or as a conseq                                                 | uence of):                   | or resy                                        |                                       |                          |                                      |                            |                               |                                               |
| hysici<br>the bu                                                                                                                                                                                              | dical          |                                                                                                              |                             | d                                 |                                                                 |                              |                                                |                                       |                          |                                      |                            |                               |                                               |
| ding p                                                                                                                                                                                                        | Mec            | IF FEMALE:                                                                                                   |                             | 000 16 100 0                      | thomas of avoire                                                |                              |                                                |                                       |                          |                                      |                            |                               |                                               |
| within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as           | Physician/Me   | 23b. Was decedent p<br>in the past 12 m<br>1 ☐ Yes 2 ☐<br>9 ☐ Unknown                                        | nonths?                     | 1 ☐Live                           | utcome pf pregna<br>birth 2  Feta<br>gnant at time of c<br>nown | al death 3                   | ☐ Ectopic pregnanc☐ Other (specify) _          | у                                     |                          |                                      | /ery<br>Day Year           |                               |                                               |
| signed b                                                                                                                                                                                                      | by             | Part II. Other signific                                                                                      | cant condition              | ons contributing to               | death but not res                                               | ulting in the                | underlying cause giv                           | en in Part I.                         |                          | 23e. Did to                          |                            |                               | the cause of death?                           |
| peen                                                                                                                                                                                                          | eted           |                                                                                                              |                             |                                   |                                                                 |                              |                                                |                                       | _                        |                                      |                            |                               |                                               |
| cate has                                                                                                                                                                                                      | Completed      |                                                                                                              |                             |                                   |                                                                 |                              |                                                |                                       |                          | 24a. Was<br>autor<br>perfo<br>11 Yes |                            | prior to condeath?            | opsy findings available ompletion of cause of |
| certif                                                                                                                                                                                                        | Be             | 25. Was case referre examiner?                                                                               |                             | Hospital:                         | /                                                               | FD/0                         | ont 20 DOA Oth                                 | ner:                                  |                          | (Check only o                        |                            | 7                             |                                               |
| r this<br>aral di                                                                                                                                                                                             | : To           | 1 ☐ Yes 2 ☑ N  27. Manner of Death                                                                           |                             | 28a. Date                         | of Injury                                                       | ER/Outpation 28b. Time       | BUIL 3 DOA                                     | 4 L Nu                                |                          | ne 5 Resid                           |                            |                               | ify)                                          |
| rr. Afte<br>e fune                                                                                                                                                                                            | tion           | 1 Natural 2 Accident                                                                                         | 5 Pending investig          | 9 '                               | nth, Day Year)                                                  | Injury                       |                                                | rƙ?<br>∣Yes 2∐1                       |                          |                                      |                            |                               |                                               |
| affer des<br>Directo                                                                                                                                                                                          | Certification: | 3☐ Suicide<br>4☐ Homicide                                                                                    | 6 ☐ Could r<br>determ       | ined 28e. Plac                    | e of injury - At he<br>ding, etc. (Specil                       |                              | treet, factory, office                         |                                       | 2                        | 8f. Location (S<br>City or Tox       |                            | Number or Rui                 | ral Route Number,                             |
| n 24 hours<br>he Funera<br>pletely fille                                                                                                                                                                      | Medical C      | 29a. Certifier (Check only one)                                                                              | Certifyin<br>Medical        | Examiner: On the                  | ne best of my kno<br>basis of examina<br>nner stated.           | owledge, dea<br>ation and/or | ath occurred at the ti<br>investigation, in my | me, date an<br>opinion, dea           | d place, a               | and due to the<br>ed at the time,    | cause(s) ar<br>date and pl | nd manner as<br>lace, and due | stated.<br>to the cause(s)                    |
| To t                                                                                                                                                                                                          | M              | 29b. Signature and ti                                                                                        |                             | ina)                              | M                                                               | 1.0.                         | 29c. Licens                                    | 0 5 .                                 | 788                      | P2                                   | 29d. Date s                | signed (Month                 | , Day, Year)                                  |
| 2                                                                                                                                                                                                             |                | 30. Name and address Theresa                                                                                 |                             |                                   | ,                                                               |                              | e, Print)<br>St Antieta                        | am Str                                | eet.                     | Hagers                               | stown.                     | Marv1                         | and 21740                                     |
| Sta<br>Registr                                                                                                                                                                                                |                | 31. Date filed (Month                                                                                        |                             | 32.                               | Redistrar's Signa                                               |                              | Cools.                                         | , , , , , , , , , , , , , , , , , , , |                          |                                      |                            | ,,                            |                                               |
|                                                                                                                                                                                                               |                |                                                                                                              |                             |                                   |                                                                 | -                            |                                                |                                       |                          |                                      |                            |                               |                                               |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Registrar Amend #29d per PHYS 02-13-08 CSTM Cate of Death

Reg. No. Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WEEDON EUGENE JAN Year Physician 12:20 AM STERLING 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1461 WEST KEY PARKWAY FREDERICK FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, Year) Apr. 2, 193 Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Yrs. 213-64-6001 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No PREDERICK FREDERICK MD. Director 10g. Citizen of What Country? 10e. Street and Number PRIMROSE COURT 21703 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ø No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MASONARY Elementary/Secondary (0-12) College (1-4or 5+) CONCRETE FINISHER 11 71+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Blackston WELDON EUGENE G. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PARKWAY FRED. MO 21702 Weedon Sister 1461 WEST KEY Laurie 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SMITH BURG CREM, FCB 3,2008 SMITHSBURG, MA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 6ARY L. ROLLINS PUNCHESSONE 9. PREDERICK MO 21701 110 WEST SOUTH ST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER **Physician** METASTATIC mon/2 /Medical Due to (or as a consequence of): LARYNX **Examiner** ANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 aftending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached for P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 1 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical **npletely** (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day Year) 02/01/2008 29c. License number 29b. Signature and title of certifie 031912

State Registrar 31. Date filed (Month, Day, Year)

FFB 1 3 2008

JULIOMEROCM, no

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Degistrar's Signature

Steward St. Spack

sute 140/

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Archie Wigfall, Jr. 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 6, 2008 2222 hrs Medical Examiner ARCHIE WIGFALL, JR. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Fort Washington Medical Center Fort Washington 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Days Min Hours Director WASHINGTON, DC 02/20/1938 1 X M 2 <del>577-48-694</del>3 69 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No MD PRINCE GEORGES FORT WASHINGTON 28a-f shov with the Maryland Directo 10g. Citizen of What Country 10e, Street and Number 10f. Zip Code notified at 20744 4310 BROOKVIEW TERRACE USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married X Yes No after 3 Widowed Divorced Give Year ARMY Yes 2 X No specify: Specify: BLACK 27 is marked other than "natural", matic event, the Medical Examiner à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Baltimore, MD 21215-0036 ment of Health and Mental Hygiene.
tant: If item 27 is marked other than
or other traumer: CAB DRIVER PRIVATE 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ARCHIE WIGFALL, SR. MATTIE JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) MD 20744 DWAYNE WIGFALL/SON 4310 BROOKVIEW TERRACE FT. WASHINGTON, 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 02/09/2008 RIVERDALE, MD tant: or of RIVERDALE CREMATORY Donation 5 Other Specify: 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service License 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Head and Torso Injuries Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED UNPENDED attending physician or use as the burial requires that the death certificate be O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g / the ? Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. è Yes 2 No 3 Probably 4 V Unknown Records, P. Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital æ Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 Other<sub>4</sub> this DOA Nursing Home 5 Residence 6 Other: 1 Ves 28a. Date of Injury After t 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Driver auto auto collision Feb 6, 2008 2137 hrs Natural Yes 2 V No 5 Pending hours after death. Funeral Director; tely filled in by the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Palmer Rd. @ Fran Del Drive, Ft. Washington, MD determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 7, 2008 d address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD

31. Date filed (Month, Day, Year) State Registrar 2008

32. Registrar's Signature

|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | 1 - For<br>State<br>Registrar                                                                      |                        | State o                      | of Marylan                                              | •                                       | artment<br>rtificate       |                       |                      |            | lental Hy                      | gien<br>Reg. N                   | ZUUO                          | 06                                        | 03               |
|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------|------------------------|------------------------------|---------------------------------------------------------|-----------------------------------------|----------------------------|-----------------------|----------------------|------------|--------------------------------|----------------------------------|-------------------------------|-------------------------------------------|------------------|
| 3                 | Physici                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | an             | 1. Decedent's Name (First, Mid                                                                     | dle, Last,             |                              |                                                         |                                         |                            |                       |                      |            | 2. Date of D<br>Month          |                                  | ay Year                       | 3. Time of                                | Death            |
| and the           | /Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | <u>Evelyn</u>                                                                                      | М.                     |                              | William                                                 | ıs                                      |                            |                       |                      |            | Februar                        |                                  |                               | 7:06                                      | _ A <sup>M</sup> |
| 7                 | Examir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | er             | 4a. Facility Name (If not instituti                                                                | . 5                    |                              |                                                         |                                         | ,.                         |                       | Location o           | of Death   |                                |                                  | c. County of Dea              |                                           |                  |
| 0                 | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | Washington Ad 5. Social Security Number                                                            | Vent<br>6. Se          |                              | 7. Age (In yrs.                                         | last birthday)                          |                            | 1 Year                | If Under:            |            | 8. Date of B                   | irth                             | Montgome<br>9. Bir            | ery<br>thplace (State o<br>ountry)        | r Foreign        |
| 3                 | Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | 577-40-9292                                                                                        | 1                      | M 21 <b>∑</b> F              | 77                                                      | Yrs.                                    | Months                     | Days                  | Hours                | Min.       | (Month, D<br>June 1            | а <i>у. Үө</i> аг<br><b>,</b> 19 | 30 Was                        | ountry)<br>shingtor                       |                  |
|                   | pur *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                | Usual Residence of Decedent  10a. State 10b. Coun                                                  | hu                     |                              | 10c Cit                                                 | y, Town or Lo                           | neation                    |                       |                      |            |                                |                                  |                               | 10d. Inside Ci                            | ty Limits        |
|                   | Maryle<br>f sho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ō              |                                                                                                    |                        |                              |                                                         |                                         |                            |                       |                      |            |                                |                                  |                               | 1 🗆 Yes                                   | _                |
|                   | 28a-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Director       | Maryland Mont  10e. Street and Number                                                              | gome                   | ry                           | S1                                                      | lver S                                  | pring<br>10f. Zip          |                       |                      |            |                                | 10g. C                           | itizen of Whal C              | ountry?                                   |                  |
|                   | h with                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | 1021 Cresthay                                                                                      | en I                   | rive                         |                                                         |                                         |                            | 2090                  | )3                   |            |                                | Un                               | ited Sta                      | ates                                      |                  |
|                   | ems .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Funeral        | 11. Marital Status                                                                                 |                        |                              | edent Ever in U                                         | .S. 13.                                 | Was Decede                 | ent of Hi             | spanic Orig          | gin? (Spe  | ecify Yes or N<br>Rican, etc.) | lo-                              | 14. Race - Am<br>Black, Whi   |                                           |                  |
| 36                | or It                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | by Fu          | 1 ☐ Never Married 2 ☐ Ma<br>3 ☑ Widowed 4 ☐ Divorce                                                |                        | 1 ☐ Yes<br>If Yes, Gi        | 2 X No<br>ive                                           |                                         | 1 ☐ Yes 2                  |                       |                      |            | ,                              |                                  |                               | 31ack                                     |                  |
| 21215-0036        | 72 hours after death with the Maryland<br>"neturel", or Items 23a or 28a-f show<br>circle Examinational be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ed b           | 15. Decede                                                                                         |                        | Year or C                    | Dates:                                                  | 16a Dece                                | dent's Usual               | Occup                 | ation                |            |                                | 16b                              | Kind of Business              | /Industry                                 |                  |
| 715               | S 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | plet           | (Specify only high<br>Elementary/Secondary (0-12                                                   | est grad               | completed) College (         |                                                         | (Give                                   | kind of work<br>DO NOT use | k done d<br>e retired | luring most          | t of worki | ng                             |                                  | vernment                      |                                           |                  |
| 212               | filed withir<br>Hygiene.<br>ther than<br>int, the w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Completed      | 12 years                                                                                           |                        | College (                    | 1-401 3+)                                               | For                                     | gein                       | Aide                  | Off:                 | icer       |                                | (S                               | tate Dep                      | partment                                  | :)               |
| nd                | d ta b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Be (           | 17. Father's Name (First, Middle                                                                   |                        | 1                            |                                                         |                                         |                            |                       |                      |            | (First, Middl                  |                                  | n Sumame)                     |                                           |                  |
| Ş                 | should be<br>and Mental<br>marked o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 은              | Casper McCu                                                                                        |                        | •                            |                                                         |                                         |                            | 15:                   |                      |            | a Will:                        |                                  |                               | T: 0 (1)                                  |                  |
| Maryland          | d 2 s<br>th ar<br>7 is<br>trau                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 19a. Informant's Name/Relation                                                                     |                        |                              |                                                         |                                         | -                          |                       |                      |            |                                |                                  | or Town, State,               |                                           |                  |
| ď                 | s 1 and Healt Healt Item 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                | Talitha Sander 20a. Method of Disposition                                                          | 's -                   | Daught                       | 20b. F                                                  | IUZI<br>Place of Dispo<br>emetery, crea | . Cres                     | that<br>e of          | ren D                | r. S       | liver i                        |                                  | ng MD 2<br>Location - City of |                                           |                  |
| D<br>D            | Pages<br>ent of<br>nt: If I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                | 1 □ Burial 2 □ Cremation<br>4 □ Donation 5 □ Other                                                 |                        | lemoval from                 |                                                         |                                         |                            |                       |                      | Feb.       | 16, 2                          | 800                              | Landove                       | er, MD                                    |                  |
| Baltimore,        | permit. Pages Department of the transmitter of the |                | 21. Signature of Funeral Service                                                                   |                        | (e)                          | -11-                                                    | -                                       |                            |                       |                      |            |                                |                                  | ral Home                      |                                           |                  |
| m                 | Depa<br>Impo<br>any is                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | DUM                                                                                                | 1.1                    | 7000                         | att.                                                    | W                                       | 001 B                      | enni                  | ing Ro               | oad,       | NE Was                         | shin                             | gton, Do                      | 20019                                     |                  |
| p                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | 23a. Part . Enter the disease, shock or heart failure. Li                                          | or compl<br>st only or | ications that one cause on o | each line                                               |                                         |                            | of dyin               | g, such as           | cardiac c  | or respiratory                 | arrest,                          |                               | Approximat<br>Interval Bet<br>Onset and I | ween             |
|                   | Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | Immediate Cause (Final disease or condition                                                        | 8                      | a                            | り                                                       | MSET                                    | es.                        |                       |                      |            |                                |                                  |                               | Onset and                                 | Jealii           |
|                   | /Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | resulting in dealh)                                                                                |                        | Due to                       | (or as a conseq                                         | uence of):                              |                            |                       |                      |            |                                |                                  |                               |                                           |                  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | -i             | Sequentially list conditions,                                                                      | t                      | Due to                       | (or as a consec                                         | uerce of                                | <u> </u>                   |                       |                      |            |                                |                                  |                               |                                           |                  |
|                   | uted<br>d<br>ansit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Examiner       | lary leading to initiaciate cause. Enter Underlying Cause (Disease or injury that initiated events | 1                      |                              | $\mathcal{C}$                                           | wede                                    | nc \                       | or                    | rest                 | _          |                                |                                  |                               |                                           |                  |
| 0,                | te be executed<br>ysicien and<br>te burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Еха            | resulting in death) Last                                                                           | <b>'</b>               | Due to                       | (or as a conseq                                         | uence of):                              |                            |                       |                      |            |                                |                                  |                               |                                           |                  |
| 3760,             | # % B                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Ical           |                                                                                                    |                        | d                            |                                                         |                                         |                            |                       |                      |            |                                |                                  |                               |                                           |                  |
| к 68              | death certifical<br>e ettending phy<br>d for use as th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Physician/Med  | IF FEMALE:                                                                                         |                        | - 4                          |                                                         | -                                       |                            |                       |                      |            |                                | - 1                              |                               |                                           |                  |
| Вох               | ath c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | lan/           | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 ➡ No                             | 2                      | 1 🗀 Live I                   | itcome of pregna<br>birth 2 □ Feta<br>nant at time of d | Ideath 3                                | Ectopic pre                |                       |                      |            |                                |                                  | 23d. Date of de<br>Month      |                                           | Year             |
| o.                | 0 0 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | yslo           | 1 □ Yes 2 🛅 No<br>9 □ Unknown                                                                      |                        | 9☐ Unkn                      |                                                         | eam 5                                   | Other (spe                 | эспу)                 |                      |            |                                |                                  |                               |                                           |                  |
| <u>a</u>          | de de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | by Ph          | Part II. Other significant condi                                                                   | tions cor              | ntributing to d              | leath bul not res                                       | ulting in the u                         | nderlying ca               | use give              | en in Part I.        |            | 23e. Did                       | tobacco                          | use coninbute                 | to the cause of c                         | leath?           |
| rds               | quires<br>in sign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                |                                                                                                    |                        |                              |                                                         |                                         |                            |                       |                      |            | 1 🗆                            | ] Yes                            | 2 <b>⊠</b> No 3 □ P           | robably 4 🗆                               | Jnknown          |
| SCO               | aw requir<br>is been si<br>2 should                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ompleted       |                                                                                                    |                        |                              |                                                         |                                         |                            |                       |                      |            | 24a. Wa                        |                                  | 24b. Were a                   | utopsy findings<br>completion of c        | available        |
| H.                | The lav                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Com            |                                                                                                    |                        |                              |                                                         |                                         |                            |                       |                      |            | per                            | opsy<br>formed?<br>2177 N        | death?                        |                                           | au 36 Oi         |
| /ita              | sician:<br>certifica<br>rector. p                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Be (           | 25. Was case referred to medic examiner?                                                           | -                      |                              |                                                         |                                         |                            |                       |                      | of Death   | (Check only                    | one)                             |                               |                                           |                  |
| of Vital Records, | Phys<br>this<br>al di                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2              | 1 ☐ Yes 2 No                                                                                       |                        |                              |                                                         | ER/Outpatier                            |                            |                       | 4 U NU               |            |                                |                                  | 6 ☐Other (Sp.                 | ecify)                                    |                  |
| no                | ing<br>After<br>unea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | tlon           | 27. Manner of Death 1 ☑ Natural 5 ☐ Pend                                                           | ling<br>tigation       | (Mon                         | of Injury<br>oth, Day Year)                             | 28b. Time o<br>Injury                   | M 28                       | Bc. Injury<br>Work    | rat<br>⟨?<br>Yes 2 □ |            | 28d. Describe                  | now in                           | ury occurred                  |                                           |                  |
| Division          | if or Attending<br>after death.<br>Director: After<br>d in by the fune                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Certification: | 3 ☐ Suicide 6 ☐ Coul                                                                               |                        | 28e. Place                   | e of Injury - At he                                     | ome, farm, sti                          |                            |                       |                      |            |                                |                                  | and Number or F               | Rural Route Num                           | ber,             |
| Ö                 | s afte                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Serti          | 4 Homicide                                                                                         |                        | build                        | ling, etc. (Specif                                      | y)                                      |                            |                       |                      |            | City or T                      | own, Sta                         | te)                           |                                           |                  |
|                   | To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | edical (       |                                                                                                    |                        | ner: On the b                | e best of my kno<br>casis of examina<br>oner stated.    |                                         |                            |                       |                      |            |                                |                                  |                               |                                           | ;)               |
|                   | To the within To the Comp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | M              | 29b. Signature and title of certif                                                                 | ier                    |                              |                                                         | 0                                       |                            | -                     | number               | 4          |                                | 29d. D                           | ate signed (Mor               | th, Day, Year)                            |                  |
|                   | ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                |                                                                                                    |                        |                              |                                                         |                                         |                            | 35                    | 58Z                  | 6          |                                |                                  | 2/9/                          | به                                        |                  |
| 1                 | (in)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | 30. Name and address of person                                                                     | n who co               | mpleted cau                  |                                                         |                                         |                            |                       |                      |            |                                |                                  |                               |                                           |                  |
|                   | (0)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | DR. HORACIO                                                                                        | J.                     | chapi                        |                                                         |                                         | roll A                     | Aven                  | ue Ta                | koma       | Park,                          | MD                               | 20912                         |                                           |                  |
|                   | Sta<br>Registr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 31. Date filed (Month, Day, Yea<br>FEB 1-2 200                                                     | 8                      | Street .                     | Registrar's Signa                                       | me                                      |                            |                       |                      |            |                                |                                  |                               |                                           |                  |

State of Maryland / Department of Health and Mental Hygiene Reg. No. 008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Beckwith-Wilson Frederick Shaun February 6, 2008 6:50 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Prince George's Prince George's Community Hospital Chever1v If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 6. Sex **Funeral** Hours 2 Min. Days 1 X M 2 □ F Months Yrs. 6, 2008 Cheverly, MD Director Feb. Usuel Residence of Decedent deeth with the Meryland 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Merylen Department of Heelth end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City. Town or Location 10a Stete 10b. County 1 X Yes 2 □ No MD Prince George's Hvattsville Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 6814 Asset Drive 20785 United States Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 1 ☑ No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Merried 3altimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 X No Specify: ۾ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Not Applicable 0 Not Applicable 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Shana Beckwith 2 Hughrow Wilson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6814 Asset Dr. Hysttsville, MD 20785 Shana Beckwith ( mother ) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/11/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 22. Name and Address of Fecility Fort Lincoln Funeral Home 21. Signature of Funeral Service Liga 3401 Bladensburg Road Brentwood, MD 20722 11 Approximate Interval Between Onset end Death 23e. Part1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical +AEHATURITY EXTREME Examiner Due to (or as e consequence of): Examiner FAILURE KESPIRATORY The lew requires thet the deeth certificete be exacuted signed by the attending physician end d be deteched for use as the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or as e consequence of). Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown ۾ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 2 ER/Outpatient 3 DOA 27. Menner of Deetl 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, efc. (Specify) 4 Homicide To the Hospital ewithin 24 hours e To the Funeral C 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of certifier 29c. License number mennes the din 28189 30. Name end-address of person who completed cause of deeth (Item 23a) (Type, Print) Chererly MD Drive 7 Kernur 3001 Hospita Mean 31. Date filed (Month, Day, Year) FEB 1 2 2008 32. Registrer's Signature

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 9, 2008 Clarine Watkins AM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Prince George's Larkin Chase Nursing & Restoration Bowie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours 1 □ M 2 1 □ F Director 129-16-1470 94 Jan. 16, 1914 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No Director Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or ? must be r 14951 Nighthawk Lane 20716 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 14. Race - American Indian "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 Highland Hospital i. Pages 1 and 2 should be filed witnent of Health and Mental Hygier rant: If Item 27 is marked other the Jury or other traumatic event, the Assistant Dietician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Champ Taliaferro Caroline Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any injury or other trau Purley H. Skip Watkins/Son 14951 Nighthawk Lane Bowie, MD 20716-1036 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cem. 2/15/2008 | Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 23a. Part. Enter the disease, or complications that shock, or heart failure. List only one cause on, cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician audua /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) ed by the a 9☐Unknown 9 ☐ Unknown s been signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Donknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 2 14 No 1 TYes 2 No 1∏ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Medical Certification: To 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 57028

OR (5)

FEB 1 3 2008

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Ave. #231

Annapolis MD 21401

State of Maryland / Department of Health and Mental Hygiene 2008-06/06 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 15, 2008 1:40 A. Virginia Lee Watring /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett Oakland Nursing & Rehabilitation 0akland If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Months 1 □ M 2 ☑ F 88 May 1, 1919 West Virginia Director 235-34-3644 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 23a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD Garrett Mtn. Lake Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23s any Injury or other traumatic event, the Medical Examiner must 705 N Street 21550 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒No Specify ģ 3 TwWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Beauty Shop Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Day Robert Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 104 Holly Lane, Mtn. Lake Park, MD 21550 Jacqueline C. Kenner, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 \ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Flanagan Hill Cemetery 2/18/08 Reed Creek, WV 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A.

Oakland, MD 21550 21. Signature of Funeral Service Licensee 21 N. Second St., Oakland, MD Katreune Durch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** theroschenou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed uleuona burial-tra by e to (or as a consequence of): physician a the burial Division or Vital Records, P.O. Box 68760, attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the I within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of berson who completed cause of death (Item 23a) (Type, Frint)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed Month, Day,

9

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUS 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Washington **Physician** 3:50pm 4a. Facility Name (If not institution, give street and number) 2008 Fe b /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) Dorchester Mallard Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 M 2021 214-32-5363 Usual Residence of Decedent Yrs. Director Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show traumetic evant, the Medical Examiner must be notified at 1 Pres 2 No Directo Cambridge MD Dorchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 718 terrace or Itams 23a ncoln Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiane. Important: If itam 27 is marked other than any injury or other traumetic avant. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Garment Industry 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McNair ISaac Viola Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pacific Avenue Cambridge, MD. 21613 Menair Walter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 14 Donation 5 Other (Specify)

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Henry Funeiral Home, P. A.

510 washington St. Cambridge MD.

23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Squamous UEars /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 \(\superscript{Yes}\) 2 \(\superscript{No}\) Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 211No or Attanding Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0059973

State Registrar

cia

on DO 100 Bramble Street

dress of person who completed cause of death (Item 23a) (Type, Print)

ohnson

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 3. Time of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** February 2008 1:53 p. Gabby Wilson Geraldine /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester Chesapeake Woods Center Cambridge 8. Date of Birth (Month, Day, Year)
Dec. 12, 1933 If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours California 1 □ M 2X F 562-40-5352 74 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show sny injury or other traumatic event, the Medical Examiner must be multilled at 1X Yes 2 No East New Market Dorchester Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21631 USA 322 Railroad Ave. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □Yes 2 No 1 Never Married X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator interior design 5+12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Raymond E. Wilson 322 Railroad Ave., East New Market, MD husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/8/08 Washington, DC Howard University \* 4 ☑Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dementia **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, and leading to innuable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) Box 68760, Completed by Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month 5 5 Other (specify) signed by the a d be detached f 1 Yes 2 No Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Concer 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? Yes 20 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes certificate Division of Vital To the Hospital or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Medical Certification: After Injury 1 Natural 2 Accident 5 Pending within 24 hours and To the Funeral Director: Altramolately filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 40059973 2/7/0 1c Cambridge, MD rson who completed cause of death (Item 23a) (Type, Print) 100 Bramble ohnson 32. Regarar's Signature 31. Date filed (Month, State Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |                                                                                                                                                                                                                                                                          |                | For                                                                                                     | State                 | of Marylar                                      |                                |                                            |                               | Mental Hygi                                    | ene                    |                                             |                               |                      |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------|--------------------------------|--------------------------------------------|-------------------------------|------------------------------------------------|------------------------|---------------------------------------------|-------------------------------|----------------------|
|                     |                                                                                                                                                                                                                                                                          |                | State<br>Registrar                                                                                      |                       |                                                 | Cer                            | tificate of l                              | Death                         |                                                | g. No. 🤈 🕦             | 08                                          | 16                            | 109                  |
| н                   | Physici                                                                                                                                                                                                                                                                  | an             | Decedent's Name (First, Middle                                                                          | e, Last)              |                                                 |                                |                                            |                               | Date of Death     Month                        | Day                    | Year                                        | 3. Time of                    | Death                |
| 1,200               | /Medic                                                                                                                                                                                                                                                                   |                | Rita                                                                                                    | Rose                  | Wi                                              | 1son                           |                                            |                               | February                                       |                        |                                             | 3:55                          | P M                  |
|                     | Examin                                                                                                                                                                                                                                                                   | er             | 4a. Facility Name (If not institution                                                                   | n, give street and nu | umber)                                          |                                | 4b. City, Town, or                         | Location of Deat              | h                                              | 4c. County             | of Death                                    |                               |                      |
|                     |                                                                                                                                                                                                                                                                          |                | Shady Grove Nu                                                                                          |                       |                                                 |                                | Rockvi1                                    |                               | T                                              | Montg                  |                                             |                               |                      |
| П                   | Funeral                                                                                                                                                                                                                                                                  |                | 5. Social Security Number                                                                               | 6. Sex<br>1 ☐ M 2XXF  | 7. Age (In yrs.                                 |                                | If Under 1 Year<br>Months Days             | If Under 24 Hrs<br>Hours Min. | (Month, Day,                                   | Year)                  | Coun                                        |                               | _                    |
| н                   | Director                                                                                                                                                                                                                                                                 |                | 137-01-9668                                                                                             | 1 W 2 2 2             | 93                                              | Yrs.                           |                                            |                               | Sept. 6                                        | , 1914                 | New                                         | Jerse                         | У                    |
| _                   | and w                                                                                                                                                                                                                                                                    |                | Usual Residence of Decedent  10a. State 10b. County                                                     |                       | 10c. Ci                                         | ty, Town or Lo                 | cation                                     |                               |                                                |                        | 10                                          | 0d. Inside Ci                 | tv Limits            |
|                     | sho<br>sho                                                                                                                                                                                                                                                               | 7              |                                                                                                         |                       |                                                 |                                |                                            |                               |                                                |                        |                                             | 1 X Yes                       |                      |
|                     | he N<br>28a-f<br>otifie                                                                                                                                                                                                                                                  | Director       | Maryland   Montgo                                                                                       | omery                 | Ge                                              | rmantov                        | 7n<br>10f. Zip Code                        |                               | 10                                             | g. Citizen of W        | /hat Coun                                   | tn/2                          |                      |
|                     | with t                                                                                                                                                                                                                                                                   |                |                                                                                                         |                       |                                                 |                                |                                            |                               | 10                                             |                        | viiat Oouii                                 | uy:                           |                      |
|                     | s 23                                                                                                                                                                                                                                                                     | erai           | 18904 Shooting                                                                                          |                       | rt<br>cedent Ever in U                          | 10 12 1                        | 20874                                      | ienanio Origin? (S            | Specify Ves or No.                             | USA<br>14 Bace         | e - America                                 | an Indian                     |                      |
|                     | item<br>item<br>ner r                                                                                                                                                                                                                                                    | Funeral        | 11. Marital Status  1 ☐ Never Married 2 ☐ Marri                                                         | Armed F               |                                                 | 13. 1                          | Was Decedent of H<br>f Yes, specify Cuba   | an, Mexican, Puer             | to Rican, etc.)                                |                        | k, White,                                   |                               |                      |
| 36                  | rs aft<br>I', or<br>kami                                                                                                                                                                                                                                                 | by F           | 3 AWidowed 4 Divorced                                                                                   | If Yes. G             | iive                                            |                                | 1□Yes Ž□No                                 | Specify:                      |                                                | Specify                | : 1.71-                                     | nite                          |                      |
| 8                   | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or items 23a or 28a-f show<br>ant, the Medical Examiner must be notified at                                                                                                      | Pa             |                                                                                                         | t's Education         |                                                 | 16a. Deced                     | dent's Usual Occup                         | ation                         | 1                                              | 6b. Kind of Bu         |                                             |                               |                      |
| 5                   | in 72<br>"na<br>ledic                                                                                                                                                                                                                                                    | Completed      | (Specify only highe                                                                                     | st grade completed,   |                                                 | (Give<br>life. L               | kind of work done of<br>OO NOT use retired | during most of wo<br>i)       | rking                                          |                        |                                             | ,                             |                      |
| 2                   | with<br>ene.<br>thar<br>he N                                                                                                                                                                                                                                             | Ē              | Elementary/Secondary (0-12)                                                                             | +2                    | (1-4or 5+)                                      | Tea                            | acher                                      |                               |                                                | Educa                  | tion                                        |                               |                      |
| 0                   | filed<br>Hygi<br>sther<br>ent, t                                                                                                                                                                                                                                         | Ö              | 17. Father's Name (First, Middle,                                                                       | Last)                 |                                                 |                                |                                            | 18. Mother's Na               | me (First, Middle, M                           | aiden Surnam           | ie)                                         | ,                             |                      |
| an                  | I 2 should be filed within 72 hours after death with the Marylar n and Mental Hygiene. I is marked other than "natural", or items 23a or 28a-f show its marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at | To Be          | John Edward D                                                                                           | olan                  |                                                 |                                |                                            | Cather                        | ine Dalto                                      | n                      |                                             |                               |                      |
| Maryland 21215-0036 | shoul<br>nd M                                                                                                                                                                                                                                                            | F              | 19a. Informant's Name/Relations                                                                         |                       |                                                 | 19b. Mailin                    | ng Address (Street                         |                               | ural Route Number,                             |                        | State, Zip                                  | Code)                         |                      |
| <u>8</u>            | od 2 %                                                                                                                                                                                                                                                                   |                | Mark Wilso                                                                                              | on / Son              |                                                 | 172 1                          | Hartford                                   | Lane New                      | ton, PA 1                                      | 8940                   |                                             |                               |                      |
| စ်                  | permit. Pages 1 and 2 should be<br>Department of Health and Menta<br>Important: If item 27 is marked<br>any injury or other traumatic ev<br>once.                                                                                                                        |                | 20a. Method of Disposition                                                                              | 11 / DOII             | 20b.                                            |                                | sition (Name of<br>matory or other place   |                               |                                                | 0c. Location -         | City or To                                  | wn, State                     |                      |
| ᅙ                   | ages<br>int of<br>t: If if                                                                                                                                                                                                                                               |                | 1 Burial 2 Cremation                                                                                    |                       | n State                                         | •                              |                                            | i i                           |                                                | autham                 | nton                                        | TDΛ                           |                      |
| Baltimore,          | it. Partme                                                                                                                                                                                                                                                               |                | 4 □ Donation 5 □ Other (S                                                                               |                       | Пе                                              | 1aware                         | Valley C                                   | ss of Facility Jo             | ch 2,08 S<br>seph Gawl                         | ler's S                | ons.                                        | Inc.                          |                      |
| Ba                  | Depa<br>Impo<br>any i                                                                                                                                                                                                                                                    |                | 21. Signature of afficial Service                                                                       |                       |                                                 |                                |                                            |                               | N.W Wash                                       |                        | _                                           |                               | 6                    |
|                     |                                                                                                                                                                                                                                                                          |                | 22a Part1 Enter the disease of                                                                          | r complications that  | auted the dea                                   |                                |                                            |                               |                                                |                        | г Б.С                                       | Approximat                    | e                    |
|                     |                                                                                                                                                                                                                                                                          |                | 23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final                  | only one cause on     | each line.                                      | 50 1101 0111                   | or the mode of dyn                         | ig, seem de saraie            | o or roop, atory are                           |                        |                                             | Interval Bet<br>Onset and I   | ween                 |
| ò                   | Physician<br>/Medical                                                                                                                                                                                                                                                    |                | disease or condition resulting in death)                                                                |                       | rhythmia                                        |                                |                                            |                               |                                                |                        |                                             |                               |                      |
|                     | Examiner                                                                                                                                                                                                                                                                 |                | , ,                                                                                                     |                       | o (or as a consec                               |                                | T 11                                       |                               |                                                |                        |                                             |                               |                      |
|                     |                                                                                                                                                                                                                                                                          | <u></u>        | Sequentially list conditions,                                                                           |                       | ngestive                                        |                                | Failure                                    |                               |                                                |                        |                                             |                               | <del></del>          |
|                     | bed<br>sit                                                                                                                                                                                                                                                               | Examiner       | Sequentially list conditions, if any local ground late cause. Enter Underlying Cause (Disease or injury | <                     |                                                 |                                |                                            |                               |                                                |                        |                                             |                               |                      |
|                     | and and                                                                                                                                                                                                                                                                  | хап            | that initiated events resulting in death) Last                                                          |                       | rial Fil                                        |                                | ion                                        |                               |                                                |                        |                                             |                               |                      |
| 8760,               | be e                                                                                                                                                                                                                                                                     |                |                                                                                                         | •                     | `                                               |                                |                                            |                               |                                                |                        |                                             |                               |                      |
| 687                 | The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit                                                                                                      | dical          |                                                                                                         | d                     |                                                 |                                |                                            |                               |                                                |                        |                                             |                               |                      |
|                     | death certific<br>attending p                                                                                                                                                                                                                                            | Physician/Me   | IF FEMALE:                                                                                              | 23c. If ves. o        | utcome pf pregn                                 | ancv                           |                                            |                               |                                                | 22d Dat                | te of delive                                | NP/                           |                      |
| Box                 | atten<br>for u                                                                                                                                                                                                                                                           | ian            | 23b. Was decedent pregnant in the past 12 months?                                                       | 1 ☐ Live              | birth 2□Fet                                     | al death 3                     | Ectopic pregnancy Other (specify)          | /                             |                                                | Mo                     |                                             |                               | Year                 |
| Ö                   | the de                                                                                                                                                                                                                                                                   | ysic           | 1 ☐ Yes 2 🖺 No<br>9 ☐ Unknown                                                                           | 9□Unki                |                                                 | dealli 5L                      | Joulet (specify)                           |                               |                                                |                        |                                             |                               |                      |
| P.0.                | v requires that the di<br>been signed by the<br>should be detached                                                                                                                                                                                                       | P              | Part II. Other significant conditi                                                                      | ons contributing to   | death but not res                               | sulting in the u               | nderlying cause giv                        | en in Part I.                 | 23e. Did tob                                   | acco use cont          | ribute to th                                | ne cause of c                 | death?               |
| ဗို                 | signe<br>signe                                                                                                                                                                                                                                                           | by             | Dementia                                                                                                |                       |                                                 |                                |                                            |                               | 1 □ Ye                                         | s 2 No                 | 3∏ Prob                                     | ably 4X                       | Unknown              |
| Ö                   | requ                                                                                                                                                                                                                                                                     | etec           | -                                                                                                       |                       |                                                 |                                |                                            |                               |                                                |                        |                                             |                               | 7-1-1-               |
| Vital Records,      | has t<br>ge 2 s                                                                                                                                                                                                                                                          | Completed by   | Impaired Ver                                                                                            | <u>itricular</u>      | Function                                        | on                             |                                            |                               | 24a. Was an autopsy                            | /                      | Were auto<br>prior to co<br>d <u>ea</u> th? | psy findings<br>mpletion of c | available<br>ause of |
| <u></u>             | cate<br>pag                                                                                                                                                                                                                                                              | Co             |                                                                                                         |                       |                                                 |                                |                                            |                               | perform<br>1 Yes 2                             | No No                  | 1 ☐ Yes                                     | 2□No                          |                      |
| /Its                | sician: The<br>certificate hi<br>rector, page                                                                                                                                                                                                                            | Be             | 25. Was case referred to medica examiner?                                                               |                       |                                                 |                                | Lou                                        |                               | ath (Check only one                            | )                      |                                             |                               |                      |
| 7                   | Physical this call dire                                                                                                                                                                                                                                                  | ို             | 1 ☐ Yes 2X No                                                                                           |                       |                                                 | ER/Outpatier                   |                                            | 4 🖾 Nursing                   | Home 5 Reside                                  |                        |                                             | y)                            |                      |
| Division or         | ding P<br>h.<br>After i<br>funera                                                                                                                                                                                                                                        | :io            | 27. Manner of Death  1X Natural 5 ☐ Pendir                                                              | ng (Mo                | e of Injury<br>onth, Day Year)                  | 28b. Time of<br>Injury         | Wor                                        |                               | 28d. Describe ho                               | w injury occuri        | red                                         |                               |                      |
| <u>S</u>            | tendi<br>leath.<br>tor: /<br>the fu                                                                                                                                                                                                                                      | Certification: | 2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could                                                              | not be                |                                                 |                                |                                            | Yes 2 ☐ No                    |                                                |                        |                                             |                               |                      |
| ⋛                   | or Attendation of Director:                                                                                                                                                                                                                                              | Ě              | 4 ☐ Homicide determ                                                                                     | ained 20t. Flat       | ce of injury - At h<br>ding, etc. <i>(Sp</i> ec | nome, farm, str<br><i>ify)</i> | eet, factory, office                       |                               | 28f. Location (Str<br>City or Town             | eet and Numb<br>State) | er or Rura                                  | ll Houte Nun                  | nber,                |
|                     | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely illed in by the funeral director,                                                                                                          |                |                                                                                                         |                       |                                                 |                                |                                            |                               | 1                                              |                        |                                             |                               |                      |
|                     | To the Hospital within 24 hours a To the Funeral I completely filled                                                                                                                                                                                                     | edical         | (Check only 2 Medical                                                                                   | Examiner: On the      | basis of examin                                 |                                |                                            |                               | e, and due to the ca<br>curred at the time, da |                        |                                             |                               | s)                   |
|                     | To the h<br>within 24<br>To the F<br>complete                                                                                                                                                                                                                            | led            | one)                                                                                                    | and ma                | nner stated.                                    |                                |                                            |                               |                                                |                        |                                             |                               |                      |
|                     | <b>7</b> ₩ 100 000 000                                                                                                                                                                                                                                                   | Σ              | 29b. Signature and title of certific                                                                    |                       | AIN                                             |                                | 29c. Licens                                | D 5505                        |                                                | d. Date signe          | u (WIONIII,                                 | ∠ay, rear)                    |                      |
| }                   | 10                                                                                                                                                                                                                                                                       |                | Chatth                                                                                                  | 19ml                  | UN                                              |                                | (1)                                        |                               | 1                                              | Februar                | ry 12                                       | , 2008                        | 3                    |
|                     | 10                                                                                                                                                                                                                                                                       |                | 30. Name and address of person                                                                          | ·                     |                                                 |                                |                                            |                               |                                                |                        |                                             |                               |                      |
|                     |                                                                                                                                                                                                                                                                          |                | Attan Kasid, M                                                                                          |                       |                                                 |                                | . Suite                                    | 409 Gait                      | hersburg,                                      | Md 208                 | 355                                         |                               |                      |
|                     | Sta<br>Regist                                                                                                                                                                                                                                                            |                | 31. Date filed (Month, Day, Year,                                                                       | 2008                  | Registrar's Sign                                | ature                          | actio 1                                    |                               |                                                |                        |                                             |                               |                      |

DHMH 17 Rev 1/2001

|             |                                                                                                                                                                                                                                                                                                  |                  | 1 - State o                                                                                               | f Marylan                                                     |                                  |                                              | lealth and N                                            | /lental Hyg                          | jiene                                   |                                                        |                                       |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------|----------------------------------------------|---------------------------------------------------------|--------------------------------------|-----------------------------------------|--------------------------------------------------------|---------------------------------------|
|             |                                                                                                                                                                                                                                                                                                  |                  | Registrar  1. Decedent's Name (First, Middle, Last)                                                       |                                                               | Cei                              | rtificate of                                 | Deam                                                    | 2. Date of Dea                       | th                                      | U 8                                                    | ime of Death                          |
| *           | Physici<br>/Medio                                                                                                                                                                                                                                                                                |                  | HARRY GOODMAN                                                                                             | WALK                                                          | ER JR                            |                                              |                                                         | Month<br>Feb                         | 7, 200                                  |                                                        | :00pm м                               |
|             | Examir                                                                                                                                                                                                                                                                                           | er               | 4a. Facility Name (If not institution, give street and number Holy Cross Hospital                         | nber)                                                         |                                  |                                              | r Location of Death<br>Spring                           |                                      | 4c. County of                           | Death<br>Domery                                        | 7                                     |
|             | Funeral                                                                                                                                                                                                                                                                                          |                  | 5. Social Security Number 6. Sex                                                                          | 7. Age (In yrs. i                                             | last birthday)                   | If Under 1 Year                              | If Under 24 Hrs.                                        | 8. Date of Birth                     |                                         | ). Birthplace (S                                       | State or Foreign                      |
| ь           | Director                                                                                                                                                                                                                                                                                         |                  | 263-30-6294 1 <sup>™</sup> 2□F                                                                            | 81                                                            | Yrs.                             | Months Days                                  | Hours Min.                                              | Jan. 28                              | 3,1927                                  | Flori                                                  | .da                                   |
|             | riand<br>ow<br>it                                                                                                                                                                                                                                                                                |                  | Usual Residence of Decedent  10a. State 10b. County                                                       | 10c. City                                                     | y, Town or Lo                    | cation                                       |                                                         |                                      |                                         | 10d. Ins                                               | side City Limits                      |
|             | e Mary<br>a-f sh<br>iiffed a                                                                                                                                                                                                                                                                     | ctor             | MD Montgomery                                                                                             |                                                               | Rockv                            | ille                                         |                                                         |                                      |                                         | 125                                                    | Yes 2 No                              |
|             | vith the                                                                                                                                                                                                                                                                                         | Dire             | 10e. Street and Number                                                                                    |                                                               |                                  | 10f. Zip Code                                | F 3                                                     | 1                                    | log. Citizen of Wh                      |                                                        |                                       |
|             | leath v                                                                                                                                                                                                                                                                                          | Funeral Director | 13521 Vandalia Drive                                                                                      | adent Ever in II                                              | S. 13. V                         | 208                                          |                                                         | ecity Yes or No-                     | U.S. 7                                  | A • American Indi                                      | an.                                   |
| 21215-0036  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by               |                                                                                                           | rces?<br>2□NJ94                                               | 5-                               | f Yes, specify Cuba<br>1 ☐ Yes <b>2</b> € No | lispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | Rican, etc.)                         |                                         | White, etc.<br>Black                                   |                                       |
| 5-0         | n 72 ho<br>"natul<br>edical                                                                                                                                                                                                                                                                      | Completed        | 15. Decedent's Education (Specify only highest grade completed)                                           |                                                               | 16a. Deced                       | dent's Usual Occup<br>kind of work done      | ation<br>during most of work<br>d)                      | king                                 | 16b. Kind of Busin                      | ness/Industry                                          |                                       |
| 121         | within iene. than "                                                                                                                                                                                                                                                                              | dmo              | Elementary/Secondary (0-12) College (* 6+                                                                 | -4or 5+)                                                      | 1                                |                                              | "<br>Enginee:                                           |                                      | Vitro                                   | Labs                                                   |                                       |
| pu          | should be filed within and Mental Hygiene. s marked other than " umatic event, the Mer                                                                                                                                                                                                           | 3e C             | 17. Father's Name (First, Middle, Last)                                                                   |                                                               |                                  |                                              | 18. Mother's Nam                                        | e (First, Middle,                    | Maiden Surname)                         |                                                        |                                       |
| ylaı        | should be<br>ind Mental<br>s marked o                                                                                                                                                                                                                                                            | To Be            | Harry G. Walker S:                                                                                        | <u> </u>                                                      | 1                                |                                              |                                                         |                                      | e Bakeı                                 |                                                        |                                       |
| Maryland    | nd 2 sh<br>Ith and<br>27 is n                                                                                                                                                                                                                                                                    |                  | 19a. Informant's Name/Relationship (Type. Print)  Stacey A. Walker-Dan                                    | ughter                                                        | 1                                |                                              | and Number or Rui<br>l Mar C:                           |                                      |                                         |                                                        |                                       |
|             | os 1 and 3<br>of Health<br>item 27                                                                                                                                                                                                                                                               |                  | 20a. Method of Disposition                                                                                | 20b. P                                                        | lace of Dispo                    | sition (Name of matory or other place        |                                                         |                                      | 20c. Location - Ci                      |                                                        |                                       |
| <u>E</u>    | Pages<br>ment of I<br>ant: If ite                                                                                                                                                                                                                                                                |                  | 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)                                |                                                               | te of                            | Heaven                                       | 2/1                                                     |                                      | Silver                                  |                                                        |                                       |
| Baltimore,  | permit. Page<br>Department of<br>Important: If<br>any Injury or                                                                                                                                                                                                                                  | _                | 21. Signature of Funeral Service Licensee                                                                 | nder                                                          | 132                              |                                              | ss of Facility <b>Sn</b><br>a <b>shi</b> ngto           |                                      |                                         |                                                        |                                       |
|             |                                                                                                                                                                                                                                                                                                  |                  | 23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on e | aused the death<br>ach line.                                  | n. Do not ente                   | er the mode of dyir                          | ng, such as cardiac                                     | or respiratory arr                   | rest,                                   | Interv                                                 | oximate<br>ral Between<br>t and Death |
| b,          | Physician /Medical                                                                                                                                                                                                                                                                               |                  | resulting in death)                                                                                       | ESPIRA'.<br>(or as a consequ                                  |                                  | FAILURE                                      |                                                         |                                      |                                         |                                                        |                                       |
|             | Examiner                                                                                                                                                                                                                                                                                         |                  | Li                                                                                                        | JNG CAI                                                       |                                  |                                              |                                                         |                                      |                                         |                                                        |                                       |
|             | sit sd                                                                                                                                                                                                                                                                                           | iner             | Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying                      | (or as a consequ                                              | uenne of):                       |                                              |                                                         |                                      |                                         |                                                        |                                       |
| ) _         | xecute<br>and                                                                                                                                                                                                                                                                                    | Examiner         | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C        | or as a consequ                                               | uence of):                       |                                              |                                                         |                                      |                                         |                                                        |                                       |
| 68760,      | ficate be executed<br>physician and<br>sthe burial-transit                                                                                                                                                                                                                                       | edical E         | d                                                                                                         |                                                               |                                  |                                              |                                                         |                                      |                                         |                                                        |                                       |
| _           | ertifical<br>ing phy<br>e as th                                                                                                                                                                                                                                                                  |                  | IF FEMALE:                                                                                                |                                                               |                                  |                                              |                                                         |                                      |                                         |                                                        |                                       |
| P.O. Box    | Physician: The law requires that the death certific<br>this certificate has been signed by the attending p<br>ral director, page 2 should be detached for use as i                                                                                                                               | Physician/M      | 23b. Was decedent pregnant 1 Live to                                                                      | come pf pregna<br>birth 2 □Fetal<br>nant at time of de<br>own | Ideath 3□                        | Ectopic pregnancy<br>Other <i>(specify)</i>  |                                                         |                                      | 23d. Date of Month                      |                                                        | Year                                  |
|             | uires that the de<br>signed by the a                                                                                                                                                                                                                                                             | by Ph            | Part II. Other significant conditions contributing to de                                                  | ath but not resu                                              | ulting in the ur                 | nderlying cause giv                          | en in Part I.                                           | 23e. Did to                          | bacco use contribi                      | ute to the caus                                        | se of death?                          |
| ğ           | w require<br>been sig<br>should be                                                                                                                                                                                                                                                               | ed b             |                                                                                                           |                                                               |                                  |                                              |                                                         | 1 🔀 Y                                | es 2□No 3                               | ☐ Probably                                             | 4 □Unknown                            |
| Records,    | sician; The law r<br>s certificate has be<br>lirector, page 2 sh                                                                                                                                                                                                                                 | Completed        |                                                                                                           |                                                               |                                  |                                              |                                                         | 24a. Was a autops perform            | moed? dea                               | re autopsy find<br>or to completio<br>ath?<br>Yes 28 N | dings available<br>n of cause of      |
| Vita        | ician;<br>sertifica<br>ector, I                                                                                                                                                                                                                                                                  | Be               | 25. Was case referred to medical examiner?                                                                |                                                               |                                  | Lau                                          | 26. Place of Deat                                       |                                      |                                         |                                                        |                                       |
| o           | Phys<br>r this<br>ral din                                                                                                                                                                                                                                                                        | 6                | 1 Yes 1 No Hospital: 1X 27. Manner of Death 28a. Date                                                     | ·                                                             | ER/Outpatien<br>28b. Time of     |                                              | 4 □ Nursing Ho                                          |                                      | ence 6 DOther                           | (Specify)                                              |                                       |
| 0<br>U      | Attending Phir death. ector; After thi                                                                                                                                                                                                                                                           | ation            |                                                                                                           | th, Day Year)                                                 | Injury                           | Wor                                          | k?<br>Yes 2 □ No                                        | Edd. Doddino iii                     | on injury occurred                      |                                                        |                                       |
| Division or | after death<br>after death<br>I Director;<br>d in by the                                                                                                                                                                                                                                         | Certification:   | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildi                                    | of injury - At ho<br>ng, etc. (Specify                        | ome, farm, stre                  | eet, factory, office                         |                                                         | 28f. Location (Si<br>City or Town    | treet and Number<br>n, State)           | or Rural Route                                         | Number,                               |
|             | To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by                                                                                                                                                                                                      | edical C         | 29a. Certifier (Check only one)  Check only one)  Addical Examiner: On the band grani                     | best of my know<br>asis of examinat<br>ner stated.            | wledge, death<br>tion and/or inv | n occurred at the tirvestigation, in my o    | ne, date and place,<br>pinion, death occur              | and due to the corred at the time, o | ause(s) and mann<br>late and place, and | er as stated,<br>d due to the ca                       | ause(s)                               |
|             | To the within 2                                                                                                                                                                                                                                                                                  | Me               | 29b. Signature, and little of certifier                                                                   | 2                                                             |                                  | 29c. Licens                                  |                                                         |                                      | 9d. Date signed (i                      |                                                        | ,                                     |
|             | (0                                                                                                                                                                                                                                                                                               |                  | · Y/                                                                                                      |                                                               |                                  | D(                                           | 54010                                                   |                                      | Feb. 7,                                 | 2008                                                   |                                       |
|             | , -                                                                                                                                                                                                                                                                                              |                  | 30. Name and address of person who completed caus Ricardo E. Dent, MD                                     |                                                               |                                  | •                                            | Rd Silv                                                 | or Co-                               | ing Mr                                  | 2001                                                   | 0                                     |
|             | Sta                                                                                                                                                                                                                                                                                              | te               | 31. Date filed (Month, Day, Year) 327                                                                     | 1                                                             |                                  |                                              | va STT/                                                 | er spr                               | THY, ML                                 | ZU91                                                   | U                                     |
|             | Registr                                                                                                                                                                                                                                                                                          | ar               | FEB 1 3 2008                                                                                              | egistrar's Signar                                             | 1- 15/04                         |                                              |                                                         |                                      |                                         |                                                        |                                       |

DHMH 17 Rev 1/2001

|            |                                                                                                                                                                                                                                          |                  | For State Registrar                                             | State             | e of Maryla                          |                           |                  | nt of H<br>te of L                       |                              | Men     | ,                                | giene<br>Reg. No | 00                | 8         | 06                       |             |
|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------|-------------------|--------------------------------------|---------------------------|------------------|------------------------------------------|------------------------------|---------|----------------------------------|------------------|-------------------|-----------|--------------------------|-------------|
| E a        | Physici<br>/Medio                                                                                                                                                                                                                        |                  | 1. Decedent's Name (First, Middle Elizabeth H                   |                   | t                                    |                           |                  |                                          |                              |         | Date of De<br>Month<br>bruar     | Day              | 200               | ear<br>08 | 3. Time o                |             |
|            | Examir                                                                                                                                                                                                                                   |                  | 4a. Facility Name (If not institution                           |                   |                                      |                           | 4b. Cit          |                                          | Location of Deat             |         |                                  |                  | County of         |           |                          |             |
|            |                                                                                                                                                                                                                                          | (B)              | Wilson Health 5. Social Security Number                         | Care Ce           |                                      | s. last birthday)         | If Und           | Gaitl<br>er 1 Year                       | hersburg                     |         | Date of Bir                      |                  | Mont              |           |                          | or Foreign  |
|            | Funeral Director                                                                                                                                                                                                                         |                  | 578-12-4861                                                     | 1 □ M 2🎇          |                                      | Yrs.                      | Month            | Days                                     | Hours Min.                   | 1 -     | Date of Bir<br>Month, Da<br>n. 1 |                  | 13                | Count     | ace (State<br>try)       |             |
| weigh.     | PL ,                                                                                                                                                                                                                                     |                  | Usual Residence of Decedent                                     |                   |                                      |                           |                  |                                          |                              |         | ****                             |                  |                   |           |                          |             |
|            | arylan<br>show                                                                                                                                                                                                                           | 5                | 10a. State 10b. County                                          |                   | 10c. C                               | City, Town or Lo          |                  |                                          |                              |         |                                  |                  |                   | 10        | od. Inside (             | Sity Limits |
|            | 28a-f                                                                                                                                                                                                                                    | ect              | MD Mon                                                          | tgomery           |                                      | Ga                        |                  | ersbut<br>ip Code                        | rg                           |         | -                                | 10a Citiz        | en of Wh          | at Count  |                          | 71          |
|            | 3a or                                                                                                                                                                                                                                    | Ö                | 409 Christophe:                                                 | r Avenue          | #24                                  |                           | 101. 2           | ip code                                  | 20879                        |         |                                  |                  | ted S             |           | •                        |             |
|            | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23e or 28e-f show other traumatic event. The Madical Examinations is prolified at | Funeral Director | 11. Marital Status                                              |                   | Decedent Ever in d Forces?           | U.S. 13.                  | Was Dec          | edent of Hi                              | ispanic Origin? (S           | Specify | Yes or No                        |                  | 4. Race -         | America   | an Indian,               |             |
| 9          | or its                                                                                                                                                                                                                                   | F.               | 1 Never Married 2 Mar                                           | ned 1 TY          | es 2 No<br>Give                      |                           | _                | ecity Cuba<br>2⊠ No                      | n, Mexican, Puer<br>Specify: | to Hica | n, etc.)                         |                  | Specify:          | White, €  | hite                     |             |
| 21215-0036 | urai',                                                                                                                                                                                                                                   | d by             | 3 X Widowed 4 □ Divorced                                        | Year              | or Dates:                            |                           |                  |                                          |                              |         |                                  |                  |                   |           |                          |             |
| 15-        | n 72<br>n "nat                                                                                                                                                                                                                           | Completed        | (Specify only highe                                             | 7                 |                                      | 16a. Dece<br>(Give        | kind of v        | ual Occupa<br>vork done d<br>use retired | during most of wo            | rking   |                                  | 16b. Kin         | nd of Busin       | ness/ind  | lustry                   |             |
| 212        | d with<br>jiene.                                                                                                                                                                                                                         | mo               | Elementary/Secondary (0-12)                                     | Colleg            | ge (1-4or 5+)                        |                           | Ног              | nemak                                    | er                           |         |                                  | 0                | wn Ho             | ome       |                          |             |
|            | e filer<br>al Hyg<br>lothe<br>vent.                                                                                                                                                                                                      | Bec              | 17. Father's Name (First, Middle,                               | Last)             |                                      |                           |                  |                                          | 18. Mother's Na              | me (Fil | rst, Middle                      | , Maiden S       | Su <i>m</i> ame)  |           |                          |             |
| ylaı       | Mente<br>Mente<br>arked                                                                                                                                                                                                                  | To               | Daniel W. Hoop                                                  | er                |                                      |                           |                  |                                          | Vern                         | a R     | ibeli                            | ln               |                   |           |                          |             |
| Maryland   | s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than other traumatic event. Items                                                                                                                 |                  | 19a. Informant's Name/Relations                                 |                   |                                      |                           | _                |                                          | and Number or Ri             |         |                                  |                  |                   |           |                          |             |
|            | 1 and<br>Health<br>em 27<br>ther t                                                                                                                                                                                                       |                  | Ouida Podlasek, 20a. Method of Disposition                      | / Daught          |                                      | 9111<br>Place of Dispo    |                  |                                          | Road, G                      | ait     | herst                            |                  | MD 2              |           |                          |             |
| nor        |                                                                                                                                                                                                                                          |                  | 1 ☐ Burial 2 ☒ Cremation<br>4 ☐ Donation 5 ☐ Other (S           |                   | rom State Me                         | cemetery, cres<br>tropoli | matory o<br>Ltan | other plac                               | Febr                         | yar     | y 7                              |                  |                   | •         |                          | dada        |
| altimore,  | コモモラ                                                                                                                                                                                                                                     |                  | 21. Signature of Funeral Service                                |                   | - 1                                  | Crema                     |                  |                                          | s of Facility                | UO      |                                  | Ale.             | xanaı             | ria,      | Virg                     | ııııa       |
| ä          | Depa<br>impo<br>eny ir                                                                                                                                                                                                                   |                  | 1RACOA                                                          | STUV              | 20                                   | I                         | )eVo             | L Fund                                   | eral Hom<br>thersbur         | e,      | 10 Ea                            | ast D            | eer I             | Park      | Driv                     | e,          |
|            |                                                                                                                                                                                                                                          |                  | 23a. Part1. Enter the disease, or shock, or heart failure. List | complications the | nat caused the de-                   | ath. Do not ent           | ter the m        | ode of dyin                              | g, such as cardia            | c or re | spiratory a                      | rrest,           |                   |           | Approxima<br>Interval Be | tween       |
| d          | Physician                                                                                                                                                                                                                                |                  | tmmediate Cause (Final disease or condition                     | . +               | fortic                               | Sten                      | 03(5             |                                          |                              |         |                                  |                  |                   | 100       | Vear                     | Death       |
|            | /Medical<br>Examiner                                                                                                                                                                                                                     |                  | resulting in death)                                             | Due               | to (or as a conse                    | equence of):              |                  |                                          |                              |         |                                  |                  |                   |           | 1                        | ,           |
| 8          | LXG!!!!!C!                                                                                                                                                                                                                               | e.               | Sequentially list conditions, if any, leading to immediate      | b. —              | to (or as a conse                    | aquence of):              |                  |                                          |                              |         |                                  |                  |                   | +         |                          | _           |
|            | uted                                                                                                                                                                                                                                     | mine             | cause. Enter Underlying<br>Cause (Disease or injury             | <                 | 7 (0, 40 4 00, 100                   | 74001100 017.             |                  |                                          |                              |         |                                  |                  |                   |           |                          |             |
| oʻ.        | execusin and rial-tra                                                                                                                                                                                                                    | Examin           | that initiated events<br>resulting in death) Last               | C. Due            | to (or as a conse                    | equence of):              |                  |                                          |                              |         |                                  |                  |                   |           |                          |             |
| 38760,     | cate be executed<br>physicien and<br>the burial-transil                                                                                                                                                                                  | dical            |                                                                 | d                 |                                      |                           |                  |                                          |                              |         |                                  |                  |                   |           |                          |             |
| _          |                                                                                                                                                                                                                                          | Med              | IF FEMALE:                                                      |                   |                                      |                           |                  |                                          |                              |         |                                  |                  |                   |           |                          |             |
| Вох        | death certific<br>e attending f<br>id for use as                                                                                                                                                                                         | Physician/Me     | 23b. Was decedent pregnant in the past 12 months?               | 1 DLi             | , outcome of pregi                   | tal death 3               |                  | pregnancy                                |                              |         |                                  | 2                | 3d. Date of Month |           | ry<br>Day                | Year        |
| o.         | 0 00 0                                                                                                                                                                                                                                   | ysic             | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown                                   |                   | regnant at time of<br>Inknown        | death 5                   | Other (          | specify)                                 |                              |         |                                  |                  |                   |           |                          |             |
| <u>a</u>   | The law requires that the tee been signed by the bage 2 should be detached.                                                                                                                                                              |                  | Part II. Other significant condition                            | ons contributing  | to death but not re                  | esulting in the u         | nderlying        | cause give                               | en in Part I.                |         | 23e. Did t                       | tobacco us       | se contribi       | ute to th | e cause of               | death?      |
| rds,       | n sign                                                                                                                                                                                                                                   | ed by            |                                                                 |                   |                                      |                           |                  |                                          |                              |         | 1 🗆                              | Yes 2□           | □No 3             | ☐ Proba   | ably 4 🔀                 | Unknown     |
| Record     | aw requisible been 2 should                                                                                                                                                                                                              | Completed        |                                                                 |                   |                                      |                           |                  |                                          |                              | -       | 24a. Was                         |                  |                   |           | sy findings              |             |
| R          | The lav                                                                                                                                                                                                                                  | Com              |                                                                 |                   |                                      |                           |                  |                                          |                              |         | auto<br>perfo                    | ormed2           | dea               | ith?      | npletion of<br>2 No      | cause or    |
| Vital      | Physician: Th<br>this certificate<br>ral director, pag                                                                                                                                                                                   | Be (             | 25. Was case referred to medica examiner?                       |                   |                                      |                           |                  |                                          | 26. Place of De              | ath (CI | neck only                        | one)             |                   |           |                          |             |
| of/        | Physi<br>this c                                                                                                                                                                                                                          | မ                | 1 Yes 2 No                                                      |                   |                                      | ER/Outpatier              | _                |                                          | 4 Nursing F                  |         |                                  |                  |                   |           | ')                       |             |
| ou c       |                                                                                                                                                                                                                                          | ion              | 27. Manper of Death  1 Natural 5 Pendir                         | ng (/             | late of Injury<br>Month, Day Year)   | 28b. Time o<br>Injury     | t<br>M           | 28c. Injury<br>Work                      | /at<br><br Yes 2 ∐ No        | 28d.    | Describe                         | how injury       | occurred          |           |                          |             |
| Division   | or Attendi<br>after death.<br>Director; A<br>in by the fu                                                                                                                                                                                | Certification:   | 2 Accident investi 3 Suicide 6 Could determ                     | not be            | lace of Injury - At                  | home, farm, str           |                  |                                          | 163 2 110                    | 28f.    | Location (                       | Street and       | Number            | or Rura   | Route Nut                | nber,       |
| <u>5</u>   | after i Dire                                                                                                                                                                                                                             | Serti            | 4  Homicide determ                                              | b b               | uilding, etc. (Spec                  | cify)                     | ,                | ,,                                       |                              |         | City or To                       | wn, State)       |                   |           |                          |             |
|            | To the Hospitel or Attending within 24 hours after death.  To the Funeral Director; After completely filled in by the fune                                                                                                               |                  | 29a. Certifier 1 Certifyir (Check only 2 Medical                | ng Physician: To  | the best of my ki                    | nowledge, deat            | h occurre        | d at the tim                             | ne, date and place           | e, and  | due to the                       | cause(s)         | and mann          | er as st  | ated.                    | (0)         |
|            | the H<br>tin 24<br>the Fi                                                                                                                                                                                                                | Medical          | one)                                                            | and r             | ne basis of examir<br>manner stated. | iation and/or in          |                  |                                          |                              | urred a | t the time,                      |                  |                   |           |                          | >)          |
|            | To con                                                                                                                                                                                                                                   | 2                | 29b. Signature and title of certifie                            |                   | 1. 5                                 |                           | 2                | 9c. License                              | 0.014 Q                      | ,       |                                  | 29d. Date        | signed (          | Month, L  | Day, Year)               | 00          |
|            | R                                                                                                                                                                                                                                        |                  | / / //                                                          | 010               | -un-ly                               |                           |                  | V.                                       | 20110                        |         |                                  | LCDU             | BEIG              | F         |                          | U 3         |
|            | .0                                                                                                                                                                                                                                       |                  | 30. Name and address of person                                  | olinsky           | cause of death (Ite                  | em 23a) (Type,            | Print)           | Au                                       | enue G                       | auth    | dess                             | dra              | Md                |           |                          |             |
|            | Sta                                                                                                                                                                                                                                      | ite              | 31. Date filed (Month, Day, Year)                               |                   | 2 degistrar's Sign                   | nature                    | 46               |                                          |                              |         | 2.010                            |                  |                   |           |                          |             |
|            | Registr                                                                                                                                                                                                                                  | rar              | FEB 1.2                                                         | ZUUS              | Filmon                               | 18 14                     | BALL             |                                          |                              |         |                                  |                  |                   |           |                          |             |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State pe May and 78 porty 24708 difficult and Mental Hygiene For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 10:31A WENDELL FEBRUARY 9 W. WILLIAMS 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1**X**M 2□F Director 89 March 6 1918 356-14-2446 Kansas Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b, County 1 ☐ Yes 2 ☑ No Director Md. Sandy Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 17215 Quaker Lane 20860 United States 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must be permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must in one. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒️
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 No White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Adult Education Educator 12 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be W. Skinner Alta R. Williams ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17215 Quaker Lane, Sandy Spring, Md. Gudrun B. Williams / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/11/08 Alexandria, Va. Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee Murry Bache P. O. Box 5038, Laytonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4 cute Covonary Insufficiency **Physician** 30 minute /Medical Due to (or as a consequence of): greater than Examiner Cardiomyopathy, Dilated 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). greater than Examine law requires that the death certificate be executed ttending physician and or use at the burial-transit Mitral Valve Regurgitation 10 years Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No cate has certificate 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 XER/Outpatient 3 □ DOA 1 Inpatient ij 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending Injury the Funeral Director; After and the funeral Director; After and the funeral Director; After and the funeral fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2

State

31. Date filed (Month, Day, Year)

FEB 14 2008

Dewett Morrism



Registrar

1 47682

February 9, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Thelma T. Weigle February 9, 3:22 a 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Hours 1 □ M 2 🕱 F Months Days 578-20-7933 84 6, Director Dec. 1923 Washington, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location show 10d. Inside City Limits r 28a-f shov notified at Funeral Director 1 ☐ Yes 2 Tx No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 13503 Sloan Street 20853 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2**X** No If Yes, Give 1 ☐ Yes 21 No Specify: Completed by Specify: White 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be find and Mental Find Mental F Be Charles E. Thomas Virginia A. Magruder ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is I Joan P. Kaibni/ Niece 13503 Sloan Street, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Febate 20c. Location - City or Town, State 12, permit. Pages Department of Important: If it any injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2008 Rockville, Maryland 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and bause on each line. 23a. Part1. Enter the disease, or comp shock, or heart failure. List only Approximate Interval Between Onset and Death immediate Cause (Final Thalamic Hemorrhage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and bunal-tran Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Coronary Artery Disease, Alzheimer's Disease 1 Yes 2 No 3 Probably 4√4Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed certificate 2 √No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 🙀 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Funeral Director:

Certification:

Medical

(Check only one)

29b. Signature and title of certifier

State Registrar

Alan R. Segal, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type Print) 1517

29c. License number d52261

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

February 9, 2008

Hugo Circlé, Silver Spring, MD 20902

32 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Arleen Beth Watsor                                                                                                                                                                                                                                                                                                                                                                                | State of Maryland / Department of Health a  1-For State Registrar  Certificate of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | and Mental Hygiene  Reg. No. 2008 0511                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| Physician/                                                                                                                                                                                                                                                                                                                                                                                        | Decedent's Name (First, Middle,Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Date of Death     3. Time of Death                                                                                            |
| Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Month February 17, 2008 Year 0514 hrs or Location of Death 4c. County of Death                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                   | Harford Memorial Hospital Havre de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                               |
| Funeral                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Foreign                                                                                                                       |
| Director                                                                                                                                                                                                                                                                                                                                                                                          | 139-34-1035 1 M 2 F 64 Yrs. Months D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Hours Min. 09/09/1943 Poreign Country) Florida                                                                                |
| à à                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10d. Inside City Limits                                                                                                       |
| e ce ce                                                                                                                                                                                                                                                                                                                                                                                           | MD Harkord Havre de Grace                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1 Yes 2 X No                                                                                                                  |
| h the Maryland 13a or 28a-f shou  officed at once.                                                                                                                                                                                                                                                                                                                                                | MD Harford Havre de Grace  10e. Street and Number 10f. Zip Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | e 10g. Citizen of What Country?                                                                                               |
| h the N                                                                                                                                                                                                                                                                                                                                                                                           | 209 War Admiral Way 21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 078 U.S.A.                                                                                                                    |
| er death with t                                                                                                                                                                                                                                                                                                                                                                                   | 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of If Yes, specify Cul                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Hispanic Origin? ( Specify Yes or No-<br>ban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black,<br>White, etc. |
| fler de<br>fr, or i<br>er mu                                                                                                                                                                                                                                                                                                                                                                      | 1 3 Wildwed 4 Divolced in 105, 5170 10an                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | No specify: Specify: White                                                                                                    |
| ours aft atural" xamine                                                                                                                                                                                                                                                                                                                                                                           | or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | pation (Give kind of work done 16b. Kind of Business/Industry                                                                 |
| 36<br>nn 72 h<br>nan "n<br>ical E                                                                                                                                                                                                                                                                                                                                                                 | Elementary/Secondary (0-12) College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | life. DO NOT use retired)                                                                                                     |
| 5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan Completed                                                                                                                                                                                                                                                                                                                     | 12 Moth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 18. Mother's Name (First, Middle, Maiden Surname)                                                                             |
| nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director                                                                                           | Helmut Auerbach                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Frances Wurst                                                                                                                 |
| 5 21<br>should<br>and Me<br>is ma<br>atic ev                                                                                                                                                                                                                                                                                                                                                      | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | treet and Number or Rural Route Number, City or Town, State, Zip Code)                                                        |
| mnd 2 sho ealth and cm 27 is traumati                                                                                                                                                                                                                                                                                                                                                             | Robert M. Watson (Husband) 209 War Ad  20a. Method of Disposition (Name of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | miral Way, Havre de Grace, MD 21078  cemetery, Date 20c. Location - City or Town, State                                       |
| Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is mijury or other traumatic                                                                                                                                                                                                                                                                          | 1 Burial 2 Cremation 3 Removal from State crematory or other place)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                               |
| altin<br>nit. Pa<br>sartmei<br>oortan<br>rry or                                                                                                                                                                                                                                                                                                                                                   | 4 Donation 5 Other Specify: KA FUTUS & CO. 21 Signature of Funeral Service Licensee 22. Name and Addr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | , Inc. 02/21/08 West Chester, PA ress of Facility Zellman Funeral Home, P.A.                                                  |
| Det Det Militia                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ashington St., Havre de Grace, MD                                                                                             |
| Physician<br>/Medical                                                                                                                                                                                                                                                                                                                                                                             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyi failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Between Onset and                                                                                                             |
| xaminer                                                                                                                                                                                                                                                                                                                                                                                           | Immediate Cause (Final disease or condition resulting in death)  a. Carbon monoxide intoxication components of the control of | licated by gastrointestinal Death                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                   | Sequentially list conditions, b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                               |
| niner                                                                                                                                                                                                                                                                                                                                                                                             | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                               |
| ted<br>Insit<br>Examine                                                                                                                                                                                                                                                                                                                                                                           | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                               |
| io, ie be executed ysician and burial - transit                                                                                                                                                                                                                                                                                                                                                   | d.   X UNPENDED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                               |
| 60,<br>ate be o<br>buria<br>Medi                                                                                                                                                                                                                                                                                                                                                                  | #2Ja,27,20a-1, perrus,go77, 3/3/0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 8 TT 23d. Date of delivery                                                                                                    |
| Sox 6876 death certificate e attending phy for use as the by sician/Ma                                                                                                                                                                                                                                                                                                                            | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 3 Ectopic pregnancy Month Day Year                                                                                            |
| Sox death of the atterner after us                                                                                                                                                                                                                                                                                                                                                                | 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                               |
| cords, P.O. Bc law requires that the det has been signed by the: 2 should be detached ft npleted by Phys                                                                                                                                                                                                                                                                                          | Part II. Other significant conditions contributing to death but not resulting in the underlying cause                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                               |
| S, P<br>uires ti<br>na signu<br>ld be d                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1 Yes 2 No 3 Probably 4 Unknown                                                                                               |
| Records, The law requires ficate has been sig                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 24a. Was an autopsy findings available prior to completion of cause of death?                                                 |
| tal Rec<br>cian: The l<br>certificate l<br>ector, page<br>EBE COM                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1 ✓ Yes 2 No 1 ✓ Yes 2 No                                                                                                     |
| Vital Rec                                                                                                                                                                                                                                                                                                                                                                                         | examiner? [Hospital: 4   Invalidate 2 of ED/Outpatient 2   DOA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ace of Death (Check only one)  Other:  Nursing Home 5 Residence 6 Other:                                                      |
| 1 of Vi<br>Jing Physi<br>I.<br>After this<br>funeral dir                                                                                                                                                                                                                                                                                                                                          | 1 V 165 2 NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Injury at Work? 28d. Describe how injury occurred                                                                             |
| ision Attendir r death. cector: A by the fu                                                                                                                                                                                                                                                                                                                                                       | Natural 5 Pending Fnd 2/17/2008 Fnd 4:00 am                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Yes 2 X № subject inhaled car exhaust                                                                                         |
| Division o spital or Attending hours after death. Increal Director: After filled in by the function:                                                                                                                                                                                                                                                                                              | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 209 War Admiral Way Havre de Grace,              |
| lospita<br>Hours<br>Uneral<br>Ly fille                                                                                                                                                                                                                                                                                                                                                            | 29a. Certifier Certifier Physician Table 200 from house day have a sub-secured of the firm                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                               |
| Division of Vital Records, P.O. Box 68760 To the Itospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physcompletely filled in by the funeral director, page 2 should be detached for use as the beneficial Certification: To Be Completed by Physician/Me | Check only  1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                               |
| Me 10 Ki To                                                                                                                                                                                                                                                                                                                                                                                       | and manner stated.  29b. Signature and title of certifier  29c. Lice                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ense number 29d. Date signed (Month, Day, Year)                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                   | Pate am- Holler us 0.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | C.M.E. February 18, 2008                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                   | Name and address of person who completed cause of death (Item 23a)     Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Street Baltimore MD 21201                                                                                                     |
| State                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Street, Baltimore, MD 21201                                                                                                   |
| Registrar                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                               |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year M Clara R. Yablon 8, 2008 February 8:08 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🛛 F 1, 82 1925 Pennsylvania Aug. 202-16-5752 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD Montgomery Silver Spring 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 3310 North Leisure World Blvd. #425 20906 U.S.A. 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Manufacturer of Elementary/Secondary (0-12) College (1-4or 5+) 12 Creative Director silk trees and plants 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isaac Terr Miriam Leah Yaffee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a, Informant's Name/Relationship (Type. Print) David Yablon - Husband 3310 N. Leisure World Blvd. #425 Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Judean Mem. Gardens 2/10/2008 Olney, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Edward Sagel Funeral Direction, Inc. Donald 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify)Hospice1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred Injury

certificate be executed Box 68760, attending physician P.O. the a þ Division or Vital Records,

Physician;

Hospital or Attending

To the within 2.

Examiner burial-trar Physician/Medical the as JSe S for detached signed by þ Completed page 2 s certificate Be this funeral After 1 Certification: death. 24 hours a er deat filled in by

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed

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**Funeral** 

Director

show r 28a-f show notified at

7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 1

72

12 should be filed w n and Mental Hygier 'Is marked other the

mit. Pages 1 and 2 should be partment of Health and Ments portant: If item 27 is marked y Injury or other traumatic e

permit. Page Department of Important: If any Injury or

**Physician** 

/Medical

Examiner

Maryland 21215-0036

Saltimore,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal he cause(s) and manner as stated. ne, date and place, and due to the cause(s)

|           | ~1\\ C    | Certifying Physicia | an: To the best o | f my knowledge, | death occurred     | at the time, da | te and place, | and due to t   |
|-----------|-----------|---------------------|-------------------|-----------------|--------------------|-----------------|---------------|----------------|
| (Check or | y/ /2 □ N | /ledical Examiner:  | On the basis of   | examination and | l/or investigation | , in my opinion | , death occur | red at the tin |
| one) /    | / / -     |                     | and manner sta    | ted.            |                    |                 |               |                |
| /         |           |                     | _ \               |                 |                    |                 |               |                |

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Who Weses St

D0064615

February 8, 2008

legi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355 Piccard Drive Rockville, MD 20850 Genevieve Anne Wroblewski, MD

State Registrar 31. Date filed (Month, Day, Year)

FEB

1 3 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 1 - For<br>Stete<br>Registrar                                                | State of Marylan                                                                    | •                              | artment of He<br>tificate of D                 | Death                                         | Reg                                    | ene 008                                       | 06116                                              |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------|------------------------------------------------|-----------------------------------------------|----------------------------------------|-----------------------------------------------|----------------------------------------------------|
|                            | Discosioni                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  | 1. Decedent's Name (First, Middle, Last,                                     |                                                                                     |                                |                                                | 1                                             | 2. Date of Death<br>Month              | Day Yeer                                      | 3. Time of Death                                   |
|                            | Physici<br>/Medio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | CHUKWUES                                                                     | BUKA A                                                                              | NUC                            | NYE                                            |                                               | 02                                     | 19 2008                                       | 2018 PM                                            |
|                            | Examir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 4a. Fecility Name (If not institution, give                                  |                                                                                     |                                | 4b. City, Town, or                             | Location of Death                             |                                        | 4c. County of Death                           | 0                                                  |
|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | (42)                                                                         | S HOSPITE                                                                           |                                | SILVE                                          | If Under 24 Hrs.                              | ING                                    | MONIC                                         |                                                    |
|                            | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | 5. Social Security Number 6. Set                                             | 7. Age (In yrs. i                                                                   | last birthday)<br>Yrs.         | If Under 1 Year<br>Months Days                 | Hours Min                                     | B. Date of Birth<br>(Month, Day, )     | (ear) 9. Birth                                | nplace (State or Foreign intry)                    |
|                            | Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | USuel Residence of Decedent                                                  |                                                                                     | 713.                           |                                                | 14 21                                         | 02 19                                  | 7008 WA                                       | ZURILAND                                           |
|                            | land<br>ow                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  | 10a. State 10b. County                                                       | 10c. City                                                                           | y, Town or Lo                  | cation                                         |                                               |                                        |                                               | 10d. Inside City Limits                            |
|                            | Mary<br>f sh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ţ                | MT                                                                           | LF                                                                                  | HWH                            | MA.                                            |                                               |                                        |                                               | 1 Yes 2 □ No                                       |
|                            | 1 the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | rec              | 10e. Street and Number                                                       |                                                                                     |                                | 10f. Zip Code                                  |                                               | 100                                    | g. Citizen of What Co                         | untry?                                             |
|                            | 3a o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0                | 8225 DELLW                                                                   | 70 0001                                                                             |                                | 207                                            | 06                                            |                                        | USA                                           |                                                    |
|                            | 72 hours after death with the Maryland<br>natural', or tems 23a or 28a-1 show<br>disal Explicate tradified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Funeral Director |                                                                              | 12. Was Decedent Ever in U.<br>Armed Forces?                                        | S. 13.                         | Was Decedent of His                            | spanic Origin? (Spec<br>n, Mexican, Puerto R  | ify Yes or No-                         | 14. Race - Amer<br>Black, White               |                                                    |
| 9                          | after<br>or Ite                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 1 Never Married 2 Married                                                    | 1 ☐ Yes 2 ☑ No<br>If Yes, Give                                                      |                                | 1 Tes, specify Cubar<br>1 ☐ Yes 2 ☑ No         | Specify:                                      | ican, etc.)                            | Specify:                                      | 5, 810.                                            |
| 21215-0036                 | raf',                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Completed by     | 3 Widowed 4 Divorced                                                         | Year or Dates:                                                                      |                                | 103 242110                                     | opecity.                                      |                                        | IST                                           | ACK                                                |
| 5-0                        | 72 h<br>'natu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ete              | 15. Decedent's Edu<br>(Specify only highest grad                             |                                                                                     | (Give                          | dent's Usual Occupa<br>kind of work done d     | uring most of working                         |                                        | 3b. Kind of Business/I                        | ndustry                                            |
| 2                          | within<br>ene.<br>than                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | E E              | Elementary/Segondary (0-12)                                                  | College (1-4or 5+)                                                                  |                                | DO NOT use retired)                            |                                               |                                        | INFR                                          | 715                                                |
|                            | e filed w<br>Il Hygiel<br>other t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 17. Father's Name (First, Middle, Last)                                      |                                                                                     | \                              | NEAN                                           | 18. Mother's Name                             | (First Middle Ma                       |                                               | 101                                                |
| Maryland                   | htal Hedot                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Be               |                                                                              | MONUE                                                                               |                                |                                                |                                               |                                        | JUONY                                         | 7                                                  |
| Ĕ                          | should I<br>nd Meni<br>marke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2                | MARTIN AN  19a. Informant's Name/Relationship (T)                            |                                                                                     | 10h Mailir                     | Address (Street a                              |                                               |                                        | City or Town, State, Z                        |                                                    |
| Ma                         | th and the and |                  |                                                                              |                                                                                     |                                |                                                | ST GLR                                        |                                        | SC MS                                         | 1 - 0:0                                            |
|                            | l ar<br>Hea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1 1              | HOLY CROSS  20a. Method of Disposition                                       | 20b. P                                                                              | lace of Dispo                  | sition (Name of                                | Da                                            |                                        | oc. Location - City or                        |                                                    |
| Baltimore,                 | 90 = 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)           | n state                                                                             | emetery, crer                  | natory or other place                          |                                               |                                        |                                               |                                                    |
| Ball                       | r ermit. Par<br>L epartmer<br>I portant<br>any injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | 21. Signature of Funeral Service I ens                                       | ade Virector                                                                        | <i>_</i>                       | Ate Anato                                      |                                               | 655 W. 1                               | Baltimore                                     | Street                                             |
|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | - 3              | 23a. Part 1. Enter the disease, or composhoot, or heart failure. List only o | ne cause on each line.                                                              | _                              |                                                | •                                             | respiratory arres                      | st,                                           | Approximate<br>Interval Between<br>Onset and Death |
|                            | Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1                | Immediate Cause (Final disease or condition resulting in death)              | EXTREM                                                                              | -                              | REMATI                                         | LRITY                                         |                                        |                                               |                                                    |
| П                          | /Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 1                                                                            | Due to (or as a consequence                                                         | uence of):                     |                                                |                                               |                                        |                                               |                                                    |
| ı                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <u>.</u>         | Sequentially list conditions, if any, leading to immediate                   | Due to (or as a consequ                                                             | uence of):                     |                                                |                                               |                                        |                                               | _                                                  |
|                            | ed<br>sit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | -ju              | cause. Enter Underlying Cause (Disease or injury                             | 240 10 (01 43 4 5511504                                                             | 201100 017.                    |                                                |                                               |                                        |                                               |                                                    |
|                            | ate be executed by sician and the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Examiner         | that initiated events resulting in death) Last                               | Due to (or as a consequ                                                             | uence of):                     |                                                |                                               |                                        |                                               |                                                    |
| 8760,                      | be e<br>sician<br>buri                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | licai E          |                                                                              |                                                                                     |                                |                                                |                                               |                                        |                                               |                                                    |
| 687                        | licate<br>phy:<br>s the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | gdic             |                                                                              |                                                                                     |                                |                                                |                                               |                                        | T. J.                                         |                                                    |
| ×                          | certif<br>nding<br>use a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | W/               | IF FEMALE:<br>23b. Was decedent pregnant                                     | 3c. If yes, outcome of pregna                                                       |                                | _                                              |                                               |                                        | 23d. Date of deli                             | very                                               |
| Box                        | death certificate be executed<br>e attending physician and<br>of for use as the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Physician/Med    | in the past 12 months?                                                       | 1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of d                                |                                | Ectopic pregnancy Other (specify)              |                                               |                                        | Month                                         | Day Year                                           |
| P.O.                       | that the de<br>ed by the detached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ysi              | 9 Unknown                                                                    | 9□ Unknown                                                                          |                                |                                                |                                               |                                        |                                               |                                                    |
|                            | that                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | by Pi            | Part II. Other significent conditions co                                     | ntributing to death but not res                                                     | ulting in the u                | nderlying cause give                           | n in Part I.                                  | 23e. Did toba                          | acco use contribute to                        | the cause of death?                                |
| g                          | quires<br>n sign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                              |                                                                                     |                                |                                                | _                                             | 1 🗆 Yes                                | : 2 □NO 3 □ Pr                                | obably 4 Unknown                                   |
| 000                        | law requires that the<br>as been signed by th<br>2 should be detache                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Completed        |                                                                              |                                                                                     |                                |                                                |                                               | 24a. Was an                            | 24b. Were au                                  | topsy findings available completion of cause of    |
| Re                         | <b>ө</b> <u>с</u> <u>ө</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Ę.               |                                                                              |                                                                                     |                                |                                                |                                               | autopsy                                | ed? death?                                    | 2 No                                               |
| a                          | ilcien: Th<br>certificate<br>rector, pag                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ပိ               | 25. Was case referred to medical                                             |                                                                                     |                                |                                                | 26. Place of Death                            |                                        |                                               | 242110                                             |
| ⋚                          | Physicien:<br>rthis certifica<br>ral director, is                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 00               | examiner?                                                                    | Hospital: 1 Impatient 2                                                             | ER/Outpatier                   | nt 3 DOA Othe                                  |                                               |                                        | nce 6 Other (Spec                             | cifv)                                              |
| of                         | Phys<br>or this<br>oral di                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 7: To            | 27. Manner of Death                                                          | 28a. Date of Injury<br>(Month, Day Year)                                            | 28b. Time o                    |                                                |                                               | 8d. Describe hov                       |                                               |                                                    |
| Division of Vital Records, | Attending I<br>ir death.<br>ector: After<br>by the funer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ţ                | 1 ☑Natural 5 ☐ Pending<br>2 ☐ Accident investigation                         | (Month, Day Year)                                                                   | Injury                         |                                                | r?<br>res 2 □ No                              |                                        |                                               |                                                    |
| isi                        | l or Attsndi<br>after death.<br>Director: A<br>I in by the fu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | fica             | 3 Suicide 6 Could not be                                                     | 28e. Place of Injury - At he                                                        | ome, farm, str                 | eet, factory, office                           | 2                                             | 8f. Location (Stre<br>City or Town,    | et and Number or Ru                           | ıral Route Number,                                 |
| á                          | after<br>after<br>Direction                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Certification;   | 4 Homicide                                                                   | building, etc. (Specify                                                             | <i>y)</i>                      |                                                |                                               | City of Town,                          | State)                                        |                                                    |
|                            | To the Hospitel or Attanding Physicien:<br>within 24 hours after death.<br>To the Funerel Director: After this certific<br>completely filled in by the funeral director,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | edical C         | 29a. Certifier 1 ☐ Certifying Phy (Check only one)                           | sicien: To the best of my kno<br>ner: On the basis of examina<br>and manner stated. | wledge, deat<br>tion and/or in | h occurred at the tim<br>vestigation, in my op | e, date and place, a<br>pinion, death occurre | nd due to the cau<br>d at the time, da | use(s) end manner as<br>te and place, and due | stated.<br>to the cause(s)                         |
|                            | To the within 2 To the complet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Me               | 29b. Signature and title of certifier                                        |                                                                                     |                                | 29c. License                                   | number                                        | 29                                     | d. Date signed (Mont                          | h, Day, Year)                                      |
|                            | To Too                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 1000                                                                         | 210                                                                                 |                                | Doc                                            | 5554                                          | 5 6                                    | 2/19/08                                       |                                                    |
|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 20 Name and address of access who                                            | ompleted cause of doath /free                                                       | 23a) /Tune                     |                                                |                                               |                                        | 1.700                                         |                                                    |
|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 30. Name and address of person who co                                        | Simpleted cause of death (item                                                      | 150<br>150                     |                                                | ST GLEN                                       | 1901                                   | PM 33                                         | 20910                                              |
|                            | Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ato              | 31. Date filed (Month, Day, Year)                                            | 32 Registrar's Signa                                                                | nture                          | JU WELL                                        | 31 OF 61                                      | v 1777                                 | 33 150                                        |                                                    |
|                            | Regist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | FEB 2 8 200                                                                  |                                                                                     | 4                              | ask s                                          |                                               |                                        |                                               |                                                    |
| DH                         | IMH 17 Rev 1/2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | . 22 - 0 200                                                                 | - Jacobson A                                                                        | - 1                            | 200                                            |                                               |                                        |                                               |                                                    |

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| 08-01430<br>Christopher Dea                                                                                         |                | Please Type<br>amuel Allen State                                                               | or Print in B<br>e of Maryland   | / Depart                      |                                 | f Health                     | n and               |                                         | ygiene                             |                        | 200                                      | 8 0611                                              |
|---------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------|---------------------------------|------------------------------|---------------------|-----------------------------------------|------------------------------------|------------------------|------------------------------------------|-----------------------------------------------------|
| Physicia<br>Medical Exami                                                                                           | an/            | Registrar<br>1. Decedent's Name (First, Middle,La<br>Christopher Dea                           |                                  |                               | ilcate Of                       | Death                        |                     |                                         | 2. Date of De<br>Month<br>February | Day<br>19, 2           | Year<br>008                              | 3. Time of Death<br>0124 hrs                        |
| 4                                                                                                                   |                | 4a. Facility Name (if not institution, gi<br>St. Agnes Hospital                                | ive street and number            | )                             |                                 | 4b. City, To<br>Baltimo      |                     | Location of Death                       |                                    | 4                      | c. County of Death                       |                                                     |
| Funeral                                                                                                             |                | Social Security Number 6.5                                                                     | Sex 7. Ac                        | ge (In yrs. las               | t birthday)                     | If Under                     |                     | If Under 24Hrs                          | . 8. Date of E                     | Birth (MM              | //DD/YYYY) 9. Bir                        | thplace (State or                                   |
| Director                                                                                                            |                | 217_11_1582                                                                                    | M 2 F                            | 37                            | Yrs                             | Months                       | Days                | Hours Min.                              | Dec.                               | 29.                    | 1970 Foreig                              | gn<br>Puntry) MD                                    |
| - v                                                                                                                 |                | Usual Residence of Decedent                                                                    |                                  |                               |                                 |                              |                     | <u></u>                                 | рест                               |                        |                                          | 10d. Inside City Limits                             |
| w any                                                                                                               |                | 10a. State 10b. County                                                                         |                                  | 10c. City, T                  | own or Locat                    |                              | ,                   |                                         |                                    |                        |                                          | 1 Yes 2 X No                                        |
| ryland<br>a-f she<br>t once                                                                                         | ctor           | MD Howa                                                                                        | rd                               |                               |                                 | Elkric                       |                     | <del> </del>                            |                                    | 10g. Cit               | tizen of What Cou                        | ntry?                                               |
| eath with the Maryland<br>items 23a or 28a-f show<br>ust be notified at once.                                       | Director       | 6036 Old Lawyer                                                                                | s Hill Roa                       | ad                            |                                 |                              | 210                 | 075                                     |                                    | U                      | nited St                                 | ates                                                |
| with t<br>ms 23s<br>be not                                                                                          |                | 11. Marital Status                                                                             | 12. Was Deceden                  | t Ever in U.S.                | . 13. Wa                        | as Deceden                   | t of His            | panic Origin? ( Sp<br>, Mexican, Puerto | ecify Yes or I                     | <b>N</b> 0-            | 14. Race - Amer<br>White, etc.           | ican Indian, Black,                                 |
| r death<br>or ites                                                                                                  | Funeral        | 1 Never Married 2 X Marrie                                                                     | 1 Yes 2                          | 2 X No                        |                                 | Yes 2                        |                     |                                         | rucan, cto.,                       |                        | T 71                                     | ite                                                 |
| rs afte<br>ural",                                                                                                   | þ              | 3 Widowed 4 Divorce  15. Decedent's Education (Specify                                         | or Dates:  only highest grade co | mpleted) 11                   | 16a. Deceder                    |                              |                     | specify:<br>ion (Give kind of v         | vork done                          | 16b.                   | Specify: WIT                             |                                                     |
| 72 hou<br>n "nat                                                                                                    | eted           | Elementary/Secondary (0-12)                                                                    | College (1-4 or                  | 1.0                           | J                               |                              | Ü                   | CO NOT use reti                         | red)                               | 1                      |                                          |                                                     |
| )036<br>vithin<br>ene.<br>er tha                                                                                    | Completed      | 12                                                                                             | 2                                |                               | Mo                              | rtgag                        |                     | roker<br>18.Mother's Name               | /C:                                | Maida                  | Mortga                                   | ge                                                  |
| 215-0036<br>be filed within 7<br>ntal Hygiene.<br>rked other than<br>ent, the Medica                                | Be Cc          | 17. Father's Name (First, Middle, Las Roy Samuel Alle                                          |                                  |                               |                                 |                              |                     |                                         |                                    |                        | Golden                                   |                                                     |
| Me Me                                                                                                               | To B           | 19a. Informant's Name/Relationship                                                             | (Type, Print )                   | _                             |                                 |                              |                     | t and Number or I                       | Rural Route N                      | umber, (               | City or Town, State                      |                                                     |
| MD<br>d 2 sho<br>lth and<br>n 27 is<br>numati                                                                       |                | Debra A. Allen                                                                                 | - Wife                           |                               |                                 |                              |                     |                                         |                                    |                        | idge, MD                                 |                                                     |
| or Hea<br>of Hea<br>If iten                                                                                         |                | 20a. Method of Disposition  1 Burial 2 X Cremation 3                                           | Removal from S                   |                               | ace of Disposematory or of      |                              | e of cer            | netery,                                 | Date                               | 200                    | . Location - City o                      | r Town, State                                       |
| Baltimore,<br>oermit. Pages I ar<br>Department of Hee<br>Important: If ite                                          |                | 4 Donation 5 Other Specia                                                                      | fy:                              |                               | Cr                              | emato                        | rv                  | 2-2                                     | 3-2008                             |                        | Odenton.                                 | MD                                                  |
| Ball<br>Permi<br>Depar                                                                                              |                | 21. ignature of Fune   Servic - ico                                                            | ensee                            |                               | 113                             | 28 S11                       | 1nhi                | ır Sprin                                | brose .<br>o Rd                    | tune<br>∆rb            | ral Home<br>outus. MD                    | e, Inc.<br>1 21227                                  |
| Physician                                                                                                           | -              | 23a. Part I. Enter the disease, or confailure. List only one confee on                         |                                  | d the death.                  | Do not enter t                  | the mode of                  | f dying,            | such as cardiac of                      | or respiratory                     | arrest, si             | hock, or heart                           | Approximate Interval<br>Between Onset and           |
| /Medical<br>-xaminer                                                                                                |                | Immediate Cause (Final disease                                                                 | <sub>a.</sub> Hanging            |                               |                                 |                              |                     |                                         |                                    |                        |                                          | Death                                               |
| 1                                                                                                                   |                | or condition resulting in death)                                                               | Due to (or as a cons             | sequence of):                 |                                 |                              |                     |                                         |                                    |                        |                                          |                                                     |
|                                                                                                                     | miner          | Sequentially list conditions,<br>if any, leading to immediate<br>cause. Enter Underlying Cause | Due to (or as a cons             | sequence of):                 |                                 |                              |                     |                                         |                                    |                        |                                          |                                                     |
|                                                                                                                     | æ              | (Disease or injury that initiated events resulting in death) Last                              | Due to (or as a cons             | sequence of):                 |                                 |                              | -                   |                                         |                                    |                        |                                          |                                                     |
| cecuted and and transit                                                                                             | a              |                                                                                                | d                                |                               |                                 |                              |                     | -                                       |                                    |                        |                                          | -                                                   |
| 760,<br>Teate be exest physician the burial                                                                         | edic           | UNPENDED                                                                                       | AMENDED                          |                               |                                 |                              |                     |                                         | -                                  | 2                      | 3d. Date of delive                       | DY.                                                 |
| 68760,<br>certificate be<br>nding physicia                                                                          | an/Medic       | IF FEMALE:<br>23b. Was decedent pregnant in the<br>past 12 months?                             | 23c. If yes, outco               |                               | 2 Fe                            | etal death                   | 3                   | Ectopic pregn                           | ancy                               |                        | Month                                    | Day Year                                            |
| or at te                                                                                                            | sici           | 1 Yes 2 No 9 Unknow                                                                            | 1                                | at time of deat               | <sup>th</sup> 5 0               | ther (Spec                   | ify) _              |                                         |                                    |                        |                                          |                                                     |
| D. B.  It the de  by the  ached f                                                                                   | Phy            | Part II. Other significant condition                                                           |                                  | ath but not res               | sulting in the                  | underlying                   | cause g             | given in Part I.                        |                                    |                        |                                          | the cause of death?                                 |
| s, P.O.<br>iires that the signed by                                                                                 | d by           |                                                                                                |                                  |                               |                                 |                              |                     |                                         |                                    |                        | ✔ No 3 Pro                               |                                                     |
| of Vital Records,  ng Physician: The law require.  the this certificate has been sineral director, page 2 should be | Completed      |                                                                                                |                                  |                               |                                 |                              | =14                 |                                         |                                    | topsy                  | prior to                                 | utopsy findings available<br>completion of cause of |
| tal Reco<br>cian: The law<br>certificate has<br>ector, page 2 s                                                     | Шo             |                                                                                                |                                  |                               | _                               |                              |                     |                                         | 1 ✔ Ye                             | rformed<br>s 2         | No 1 V                                   |                                                     |
| cian:                                                                                                               | Be C           | 25. Was case referred to medical examiner?                                                     | Hospital:                        |                               |                                 |                              |                     | Other Nursi                             |                                    | Desi                   | dence 6 Oth                              |                                                     |
| of Vit<br>ing Physic<br>After this c                                                                                | ၉              | 1 Yes 2 No<br>27. Manner of Death                                                              | 28a. Date of In                  | ient 2 🗸 E                    | 28b. Time of                    |                              |                     | ry at Work?                             | ng Home 5 28d. Describ             |                        | dence 6 Other                            | er.                                                 |
| on of anding Ph.                                                                                                    | Certification: | 1 Natural 5 Pending                                                                            | FOUND: Day                       | Year)                         | FOUND:<br>0002 hrs              |                              | 1                   | Yes 2 🗸 No                              | Subject h                          | anged                  | self                                     |                                                     |
| Division tall or Attendin rs after death.                                                                           | ifica          | 2 Accident Investigate 3 ✓ Suicide 6 Could not                                                 | 28e Place of                     | -                             |                                 | eet, factory,                | office b            | ouilding, etc.                          | or Town                            | State)                 |                                          | Rural Route Number, City                            |
| Divisior Hospital or Attend 24 hours after death Funeral Director:                                                  | Cert           | 4 Homicide determin                                                                            | (0000.)/                         |                               |                                 |                              |                     |                                         | 6036 Old L                         | awyerś                 | Hill Road, Elkri                         |                                                     |
| Di<br>To the Hospital<br>within 24 hours a<br>To the Funeral I                                                      |                | 29a. Certifier 1 Certifying Physone) 2 Medical Examin                                          | ician: To the best of i          | my knowledge<br>amination and | e, death occu<br>d/or investiga | irred at the<br>ation, in my | time, da<br>opinion | ate and place, and<br>n, death occurred | d due to the ca<br>at the time, da | ause(s) a<br>ite and p | and manner as sta<br>place, and due to t | ated.<br>the cause(s)                               |
| To t<br>To t                                                                                                        | Medical        | 29b Signature and title of certifier                                                           | and manner stated                | d                             |                                 |                              | _                   | e number                                |                                    |                        | d. Date signed (M                        |                                                     |
|                                                                                                                     |                | Pat ()                                                                                         | - 1200 L                         |                               |                                 |                              | O.C.                | M.E.                                    |                                    | Fe                     | ebruary 19, 20                           | 800                                                 |
|                                                                                                                     |                | 30. Name and address of person wh                                                              |                                  |                               |                                 |                              |                     |                                         |                                    |                        |                                          |                                                     |
| 5                                                                                                                   |                | Patricia Aronica-Pollak N                                                                      | - 1                              |                               |                                 | <i>g</i>                     | enn St              | treet, Baltimo                          | re, MD 212                         | 201                    |                                          |                                                     |
| S<br>Regis                                                                                                          | tate<br>trar   | 31. Date filed (Month, Par Year) 8                                                             | 2008 32. Registr                 | rar's Signatus                | - Apr                           | Sell 1                       |                     |                                         |                                    |                        |                                          |                                                     |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Willie Anderson, Jr. 02 24 1:55 P M /Medical 2008 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex . Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 217-26-5347 1 X M 2 □ F 78 CT Director Jan. 23, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show at r 28a-f sh notified Director Yes 2 No MD Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? o e 2506 Chelsea Terrace 21216 ral", or Items 23a Examiner must b USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status African American 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced "natural", Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) processor Holly Poultry Pages 1 and 2 should be filed w treent of Health and Mental Hygie tant: If item 27 is marked other t ijury or other traumatic event, th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Anderson, Sr. Mary Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah McKnight / Granddaughter 4315 Blakely Avenue; Baltimore, Maryland 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If i 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 03/ 01/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or comshock, or heart failure. List only lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Carcinono Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use co ribute to the cause of death? <u>Ş</u> pe 2 No 3 Probably 4 Unknown 1 TYes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has certificate 1∐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 217 No P 1 Yes 2 ER/Outpatient 1 Inpatient 3□ DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. May er of Death 28b. Time of 28d. Describe how injury occurred after death. Director: After 1 / Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ca 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DRIAN

Date filed (Month, Day,

0

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year ANTLITZ 10:55 PM MARY FEBRUARY 25 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL HARBOR BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 X F Months Days Hours 79 Director 220-24-9365 Oct. 11,1928 Marvland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County ns 23a or 28a-f show must be notified at 10d. Inside City Limits Director 1 □Yes 2 X No Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21122 1725 Bayside Beach Road Funeral if Health and Mental Hygiene.
item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner my 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) should be filed within 72 hours after on Mental Hygiene.

marked other than "natural", or iter 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evelyn Pre11 David A. Halley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew A. Antlitz Jr. (Husband) 1725 Bayside Beach Road, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery | 02-29-08 Brooklyn Park, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensi 22. Name and Address of Facility McCully-Polyniak Funeral Home 3204 Mountain Road, Pasadena, P.A. Maryland 21122 23a. P.11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death wilediate Cause (Final isease or condition resulting in death) Physician PNEUMONIA UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) certificate be executed that initiated events resulting in death) Last and Box 68760, Due to (or as a consequence of) physician s the burial Physician/Medical ding IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ FAILWRE To THRIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: al or Attending F after death. I Director: After d in by the funera After 1 Natural 5 ☐ Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the l within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PHYSICIAN RES 001 FEBRUARY 25 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMZEH ZADEH BALTIMORE MD 21225 SAYEH 3001 HANOVER STREET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

08-01564 Warren Adams Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Varren Adams                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1-             | Sta<br>For State                                                                               | ate of Mary                         | land / l                 |                      | rtment of<br>tificate of           |                             | and                     | Menta                     | ıl Hyg                |                                 | eg. No           | 20                                   | 0.8                    | 0612                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------|----------------------|------------------------------------|-----------------------------|-------------------------|---------------------------|-----------------------|---------------------------------|------------------|--------------------------------------|------------------------|----------------------------------------------|
| Physician/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | gistrar<br>Decedent's Name (First, Middle                                                      | e,Last)                             |                          |                      |                                    |                             | _                       |                           |                       | Date of Dea                     | ith              |                                      |                        | of Death                                     |
| Medical Examine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | r              | Warren Adams                                                                                   |                                     |                          |                      |                                    |                             |                         |                           |                       | Month<br>February               |                  |                                      |                        | 5 hrs                                        |
| 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 48             | a. Facility Name (if not institution<br>2808 W. Garrison Ave                                   |                                     | number)                  |                      | 4                                  | b. City, Too<br>Baltimo     | re                      |                           |                       |                                 |                  | 4c. County of Dea                    |                        |                                              |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5.             | . Social Security Number unk                                                                   | 6. Sex                              |                          | (In yrs. Ia<br>41    | ast birthday)<br>Yrs.              | If Under<br>Months          |                         | If Under:                 | Min                   | 8. Date of Bi<br>Decembe        |                  | 7, 1966                              |                        | State or MD                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | _              | sual Residence of Decedent                                                                     |                                     | 14                       | Oo City              | Town or Location                   | 20                          |                         |                           |                       |                                 |                  |                                      | 10d. In:               | side City Limits                             |
| ow any                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11             | 0a. State 10b. County                                                                          |                                     | ľ                        | oc. Gity,            | TOWITOT LOCALI                     |                             | 1timo                   | ro                        |                       |                                 |                  |                                      |                        | Yes 2 No                                     |
| Maryland 28a-f show datones                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1              | 0e. Street and Number                                                                          |                                     |                          |                      |                                    | 10f. Zip C                  |                         |                           |                       | 1                               | 10g. C           | Citizen of What Co                   | untry?                 |                                              |
| the Maryland a or 28a-f sh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | 2808 West Garri                                                                                | son Avenue                          | ,                        |                      |                                    |                             | 2                       | 1216                      |                       |                                 |                  | USA                                  |                        |                                              |
| Baltimore, MD 21215-0036  Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To De Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | Marital Status                                                                                 | 12. Was D                           | Decedent E               | ver in Ü.            | S. 13. Wa                          | s Deceden<br>es, specify    | of Hispa                | anic Origin               | n? ( Spe<br>Puerto R  | cify Yes or Nican, etc.)        | 0-               | 14. Race - Ame<br>White, etc.        |                        |                                              |
| fler de la                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                | 3 Widowed 4 Div                                                                                | orced If Yes, Give '                |                          | NO                   |                                    | Yes 2X                      |                         |                           |                       |                                 |                  | Specify:                             |                        |                                              |
| nours after a standard and a standar |                | 15. Decedent's Education (Spec                                                                 | cify only highest g                 |                          |                      | 16a. Deceden<br>during m           | t's Usual O<br>ost of work  | ccupations              | n (Give ki<br>OO NOT u    | nd of wo              | rk done<br>d)                   | 16b              | . Kind of Busines                    | s/Industry             |                                              |
| 5-0036 ed within 72 hour hygiene. other than "natu the Medical Exal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | אפור           | Elementary/Secondary (0-12)  11 th                                                             | College                             | e (1-4 or 5-             | +)                   |                                    | 1.                          | abore                   | r                         |                       |                                 | 1                | hauling co                           | ompany                 |                                              |
| 21215-0036 Mental Hygiene. marked other than re event, the Medica                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <u> </u>       | 7. Father's Name (First, Middle,                                                               | Last)                               |                          |                      | L                                  |                             | 18                      | 3. Mother's               |                       |                                 |                  | en Surname)                          |                        |                                              |
| 215<br>be file<br>ntal Hy<br>rked o<br>ent, th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ונו            | Frank A                                                                                        | dams                                |                          |                      |                                    |                             |                         |                           |                       | Marie E                         |                  |                                      |                        |                                              |
| D 21<br>hould den<br>is man                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 2 1            | 9a. Informant's Name/Relations                                                                 |                                     |                          |                      |                                    |                             |                         |                           |                       |                                 |                  | , City or Town, Sta                  |                        | ode)                                         |
| MD and 2 sho salth and em 27 is raumati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | -              | Marie Adams / M                                                                                | other                               |                          | 20b.                 | Place of Dispos                    |                             |                         |                           | <i>r</i> enue         | ; Balti<br>Date                 | more<br>20       | e. MD 2121<br>oc. Location - City    | or Town, S             | State                                        |
| Ore<br>ges 1 a<br>t of He<br>t If it                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | 1 X Burial 2 Cremation                                                                         | 3 Remova                            | al from Sta              | te                   | crematory or ot                    | her place)                  |                         | - 1                       | 02/2                  | 8/2008                          | Ba               | altimore, M                          | Maryla                 | nd                                           |
| Baltimore,<br>permit. Pages 1 an<br>Department of Hee<br>Important: If ite                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | 4 Donation 5 Other Sp<br>21. Signature of Funeral Service                                      | pecify:<br>Ligensee                 |                          | MOU                  | nt Zion (                          | Name and                    | ry<br>Address           | of Facility               | Wz1i                  | e Fimer                         |                  | Home, P.A.                           |                        |                                              |
| Ba<br>perm<br>Depa<br>Imp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | Junada                                                                                         | ( donna                             | $\supset$                |                      | 63                                 | 8 N. G                      | ilmor                   | Stree                     | et: B                 | áltimor                         | e. N             | (D 21217                             |                        |                                              |
| Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1              | 23a. Part I. Enter the disease, or failure. List only one cause                                | complications the                   | at caused t              | the death            | n. Do not enter t                  | he mode o                   | f dying, s              | uch as ca                 | rdiac or              | respiratory a                   | rrest,           | shock, or heart                      |                        | roximate Interval<br>ween Onset and<br>Death |
| /Medical aminer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | Immediate Cause (Final disease or condition resulting in death)                                |                                     |                          |                      | ol intoxi                          | cation                      | and                     | cocair                    | ne us                 | e                               |                  | By the                               | -                      | Death                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                |                                                                                                | Due to (or a                        | as a conse               | quence o             | от):                               |                             | V                       |                           |                       |                                 |                  |                                      |                        |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | Sequentially list conditions,<br>if any, leading to immediate<br>cause. Enter Underlying Cause | Due to (or a                        | as a conse               | quence o             | of):                               |                             |                         |                           |                       |                                 |                  |                                      |                        |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Εŀ             | (Disease or injury that initiated events resulting in death) Last                              | Due to (or a                        | as a conse               | quence o             | of):                               |                             |                         |                           |                       |                                 |                  |                                      | 20                     |                                              |
| ecuted<br>and<br>transi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <u> </u>       |                                                                                                | d                                   |                          |                      |                                    |                             |                         |                           |                       |                                 |                  |                                      | +                      |                                              |
| 0, e be executed ysician and burial - transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | edical         | X UNPENDED                                                                                     | X AMENDE                            | perFH.                   | #23                  | a,27,28a-                          | f, per                      | ME,g8                   | 377_3/                    | 10/08                 | <u> TT</u>                      |                  | 23d. Date of deli                    | verv                   |                                              |
| 876 trificate ng phy as the l                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ⋝╵             | IF FEMALE:<br>23b. Was decedent pregnant in t<br>past 12 months?                               | 23C. If y                           | es, outcom<br>ve birth   | ne of preg           | griancy                            | etal death                  | 3 [                     |                           | pregna                |                                 |                  | Month                                | Day                    | Year                                         |
| ox 6 ath cer ath cer attendi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Sicia          |                                                                                                |                                     | regnant at<br>nknown     | time of d            | eath 5 O                           | ther (Spec                  | cify)                   |                           |                       |                                 |                  |                                      |                        |                                              |
| of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed wher this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - trans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ≥ા             | Part II. Other significant condi                                                               | 90                                  |                          | n but not            | resulting in the                   | underlying                  | cause g                 | iven in Pa                | irt I.                | 23e. Did                        | toba             | cco use contribute                   | to the car             | use of death?                                |
| P.C es that igned I be deta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ≦              |                                                                                                |                                     |                          |                      |                                    |                             |                         |                           |                       | 1 🗆 🕻                           | r'es             | 2 No 3 I                             | <sup>2</sup> robably   | 4 V Unknown                                  |
| rds, requir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Completed      |                                                                                                |                                     |                          |                      |                                    |                             |                         |                           |                       | 24a. Wa<br>au                   | topsy            | prior                                | to comple              | findings available<br>tion of cause of       |
| eco<br>he law<br>ate has                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | E I            |                                                                                                |                                     |                          |                      |                                    |                             |                         |                           |                       | 1 <b>✓</b> Ye                   | rforme<br>s 2    |                                      | Yes                    | 2 No                                         |
| al R                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Be C           | 25. Was case referred to medic examiner?                                                       |                                     |                          |                      |                                    |                             |                         | of Death<br>Other         | -                     |                                 |                  |                                      |                        |                                              |
| Vit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ၜ              | 1 ✓ Yes 2 No                                                                                   | Hospital: 1                         | Inpatie                  |                      | ER/Outpatier<br>28b. Time of       |                             |                         | ry at Work                |                       | g Home 5                        |                  | sidence 6 🗸 C                        | ther: Scen             | ne                                           |
| n of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | 27. Manner of Death  1 Natural 5 Per                                                           | (N                                  | Date of Injudenth, Day,Y | 'ear)                | 1                                  | ·                           |                         | res 2X                    |                       | unk                             |                  | • •                                  |                        |                                              |
| Division tal or Attendin ts after death. al Director: A led in by the fi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Certification: | 2 Accident Inv                                                                                 | estigation FIG                      | 1 2/23,<br>Place of In   | / 2008<br>ijury - At | Fnd 7:3                            | eet, factory                | , office b              | uilding, et               | tc.                   | 28f. Locatio                    | n (Stre          | eet and Number o                     | r Rural Ro             | oute Number, City                            |
| Divis<br>ital or A<br>urs after or<br>ral Direc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>\</b>       | 3 Suicide 6 X Condet  4 Homicide                                                               | ermined (Spe                        |                          |                      | in a row                           |                             |                         |                           |                       | 2808 W.                         | Ga.              | e)<br>rrison Ave                     | Balti                  | more, MD                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Medical C      | 29a. Certifier 1 ☐ Certifying I (Check only one) 2 ✔ Medical Ex                                | Physician: To the aminer: On the ba | asis of exa              | y knowle<br>mination | edge, death occ<br>and/or investig | urred at the<br>ation, in m | e time, da<br>y opinion | ate and pla<br>, death oc | ace, and<br>ccurred a | due to the c<br>at the time, da | ause(s<br>ate an | s) and manner as<br>d place, and due | stated.<br>to the caus | se(s)                                        |
| To To com                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ĕ              | 29b. Signature and title of certif                                                             |                                     | ner stated.              |                      |                                    | 29                          | c. Licens               | e number                  |                       |                                 | 2                | 29d. Date signed                     | (Month, D              | ay,Year)                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | Meline B                                                                                       | ramell                              | M                        | )                    |                                    |                             | O.C.                    | M.E.                      |                       |                                 |                  | February 24,                         | 2008                   |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ŀ              | 30. Name and address of person                                                                 |                                     |                          |                      |                                    | Penn Si                     | reet C                  | Raltimor                  | e MD                  | 21201                           |                  |                                      |                        |                                              |
| () \                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | Melissa Brassell, MD                                                                           |                                     | Medica<br>2. Registra    |                      | ature                              |                             |                         |                           | U, IVID               | 21201                           |                  |                                      |                        |                                              |
| Sta<br>Registr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ile.           | 31. Date filed (Month, Day, Year                                                               | 8 2008                              | Ma.                      |                      | Are got                            | and I                       |                         |                           |                       |                                 |                  |                                      |                        |                                              |

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amend items 13 1/4 per ab 30 per dyr of 8876 2-28-08 tyt Hygiene 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day February 8, 2008 **Physician** 10:00 PMM Donald Jessup Baker /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Silver Spring Montgomery 9913 Edgehill Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ₹M 2 □ F Months Days Hours Yrs. 79 Director May 7, 1928 299-22-1762 Indiana Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene. I other than "natural", or Itema 23e or 28a-f ahov Ivant, the Medical Examiner must be notified at 1 ☐ Yes 2√ No MD Directo Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9913 Edgehill Lane 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 146-48 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) professor College 12 27 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William lawrence Baker Minerva Jessup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Baker/spouse 9913 Edgehill Lane Silver Spring, MD 20901 itam 27 itam 27 other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important; if any injury or once. 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service I censee ROTIATO Wade. Director mas Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** carcinoma of the lung 6 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death signed by the all 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signated by should be coronary artery disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Valenown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No history of cerebral vascular accident 25 100 this certificate pneumonia treated December 2007 1 ☐ Yes 2 2 No Hospitel or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 ☐ Yes 2 🔀 No After thi 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 Tes 2 No investigation by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter de To the Funeral Direct completely filled in by t 4 | Homicide 29a. Certifier to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kabert H JOLE D-0055522 Feb 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert H. Gerard Silver Spring, Md 31. Date filed (Month, Day, Year) FEB 2 8 32. Sgistrar's Signature State Registrar

DHMH 17 Rev 1/2001

# Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed

|                                     | 1 - State<br>Registrar  1. Decedent's Nam                                                                           | ne (First Middle, L                   | ast)                                                                 |                                              | Cer                              | tificate of                               | Death                                    | 2. Date of De                     | Reg. No.                | 2008                       | 3. Time of Deat                                                        |  |
|-------------------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------------------------------|----------------------------------------------|----------------------------------|-------------------------------------------|------------------------------------------|-----------------------------------|-------------------------|----------------------------|------------------------------------------------------------------------|--|
| ian<br>ical                         |                                                                                                                     | Blimline                              |                                                                      |                                              |                                  |                                           |                                          |                                   |                         | 9, 2008                    |                                                                        |  |
| ner                                 |                                                                                                                     | If not institution, g                 | ive street and numbe                                                 | r)                                           |                                  | 4b. City, Town, o                         | r Location of Deat                       | h                                 |                         | County of Deat             |                                                                        |  |
|                                     | 5. Social Security I                                                                                                | Number 6.                             | •                                                                    | Age (In yrs. I                               | ast birthday)<br>Yrs.            | If Under 1 Year<br>Months Days            | If Under 24 Hrs.<br>Hours Min.           |                                   | rth<br>av, Year)        | 9. Birt                    | hplace (State or For<br>untry)<br>yland                                |  |
|                                     | Usual Residence of                                                                                                  |                                       |                                                                      | 40- 0"                                       |                                  |                                           |                                          | 0011 27                           | ,                       | , 1141                     |                                                                        |  |
| 'n                                  | 10a. State                                                                                                          | 10b. County                           |                                                                      | 1                                            | , Town or Lo                     |                                           |                                          |                                   |                         |                            | 10d. Inside City Lir<br>1√∑Yes 2□                                      |  |
| Director                            | 10e. Street and Nu                                                                                                  | ımber                                 |                                                                      | Da                                           | TCTINOL                          | 10f. Zip Code                             |                                          |                                   | 10a. Citiz              | zen of What Co             |                                                                        |  |
| Ö                                   |                                                                                                                     | Charles                               | Street                                                               |                                              |                                  |                                           | 1212                                     |                                   | 7-9.                    | USA                        | ,                                                                      |  |
| Funeral                             | 11. Marital Status                                                                                                  |                                       | 12. Was Deceder                                                      | t Ever in U.                                 | S. 13. \                         |                                           | lispanic Origin? (S<br>an, Mexican, Puer | pecify Yes or N                   | 0-                      | 14. Race - Ame             |                                                                        |  |
| l by Fui                            | 1 □ Never Mar<br>3 <b>X</b> I Widowed                                                                               | ried 2 Married<br>4 Divorced          | Armed Force: 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates                  | No                                           |                                  | r Yes, specify Cub<br>☐ Yes 2 <b>)</b> No | an, Mexican, Puer                        | to Hican, etc.)                   |                         | Black, White<br>Specify: W | e, etc.<br>hite                                                        |  |
| etec                                | (Spe                                                                                                                | 15. Decedent's lecify only highest g  | Education rade completed)                                            |                                              | (Give                            | ent's Usual Occup                         | during most of wo.                       | rking                             | 16b. Kii                | Kind of Business/Industry  |                                                                        |  |
| Completed                           | Elementary/Sec                                                                                                      |                                       | College (1-4o                                                        | r 5+)                                        | life. L                          | OO NOT use retire                         | d)                                       | Ü                                 | ,, ,                    |                            |                                                                        |  |
| S                                   | 1.2<br>17. Father's Name                                                                                            | (First Middle La                      | 0                                                                    |                                              | prod                             | unk unk                                   | 18. Mother's Nar                         | me (First Middle                  | 1                       | tin Mar:                   |                                                                        |  |
| Be                                  | 17.1 attiet 3 Name                                                                                                  | (i ii st, ivilodio, La.               | , , , , , , , , , , , , , , , , , , ,                                |                                              |                                  | unk                                       | To: Mother 5 Har                         | ne (i noi, whoan                  | , maiden                | ourname)                   | un]                                                                    |  |
| 욘                                   | 19a. Informant's N                                                                                                  | lame/Relationship                     | (Type, Print)                                                        |                                              | 19b. Mailin                      | g Address (Street                         | and Number or Ri                         | ural Route Numi                   | ber, City o             | r Town, State, 2           | Zip Code)                                                              |  |
|                                     | Sam Jafi                                                                                                            | a/cousir                              | L                                                                    |                                              | 1                                | •                                         | Valley                                   |                                   |                         |                            | 21120                                                                  |  |
| To Be Completed by Funeral Director | 4 XI Donation                                                                                                       | ☐Cremation 3                          | □Removal from Sta                                                    |                                              |                                  | sition (Name of<br>natory or other pla    | ce)                                      | Date                              | 20c. Lo                 | cation - City or           | Town, State                                                            |  |
|                                     | 21. Signature of F                                                                                                  | meral Service Lic<br>Conald S         | wade 101                                                             | rector                                       | ; St                             | Name and Addre<br>ate Anat<br>ltimore,    | omy Boar                                 | d 655 W                           | . Bal                   | timore                     | Street                                                                 |  |
|                                     | 23 Part1 Enter<br>shoc or he<br>Immediate ause<br>disease or conditi<br>resulting in death)                         | (Final                                | - un                                                                 | ed the death<br>line.                        | n. Do not ente                   |                                           |                                          |                                   | arrest,                 |                            | Approximate<br>Interval Betweer<br>Onset and Death                     |  |
| edical Examiner                     | Sequentially list or it any, leading to acuse. Enter Und Cause (Disease of that initiated event resulting in death) | erlying<br>r injury                   | с                                                                    | as a consequ                                 | autiou off;                      | latin                                     |                                          |                                   |                         |                            | yeas                                                                   |  |
| hysician/Medi                       | IF FEMALE:<br>23b. Was decede<br>in the past 1<br>1 ☐ Yes 2<br>9 ☐ Unknow                                           | ? months?                             | 23c. If yes, outcon<br>1 ☐ Live birth<br>4 ☐ Pregnant<br>9 ☐ Unknown | 2 Fetal                                      | I death 3                        | Ectopic pregnanc                          | у                                        |                                   | 2                       | 23d. Date of del<br>Month  | livery<br>Day Year                                                     |  |
| by P                                |                                                                                                                     | ~ ·                                   | contributing to death                                                |                                              | ulting in the ur                 | nderlying cause giv                       | ven in Part I.                           |                                   |                         |                            | the cause of death                                                     |  |
| Completed                           | 25. Was case refe                                                                                                   |                                       |                                                                      |                                              |                                  |                                           | 26. Filess of De                         | 24a. Was<br>auto<br>peri<br>1 Yes | opsy<br>formed?<br>2 No | prior to death?            | utopsy findings avail<br>completion of cause<br>2 \( \sum \text{No} \) |  |
| Certification: To Be                | examiner? 1 Yes 2  27. Manner of Dea Natural 2 Accident 3 Suicide                                                   | 5 ☐ Pending investigati 6 ☐ Could not | 28a. Date of In<br>(Month, I                                         | njury<br>Day Year)                           | ER/Outpatien 28b. Time of Injury | 28c. Inju<br>Wo                           | ner:<br>4 ☐ Nursing F                    | Home 5 ☐ Res<br>28d. Describe     | sidence (<br>how injur  | y occurred                 | ural Route Number,                                                     |  |
| edical Certif                       | 4 Homicide  29a. Certifier (Check only one)                                                                         |                                       | building, Physician: To the be aminer: On the basis                  | etc. (Specify<br>st of my know<br>of examina | v)<br>wledge, death              | occurred at the t                         |                                          | City or To                        | own, State              | and manner as              | s stated.                                                              |  |
| Mec                                 | one) and manner stated.                                                                                             |                                       |                                                                      |                                              |                                  |                                           |                                          |                                   |                         |                            | th, Day, Year)                                                         |  |
|                                     | ► A                                                                                                                 | warl                                  | w                                                                    |                                              |                                  | DS                                        | 2028                                     |                                   | Feb                     | rigary.                    | 20 2003                                                                |  |
|                                     | A Pa                                                                                                                | ress of person wh                     | o completed cause o                                                  |                                              | 70 ( Type,                       | Charle                                    | 5 ST 70                                  | NSON N                            | 10 Z                    | 4204                       |                                                                        |  |

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| Vital                                      | iclan:                                                                                          |
| ō                                          | Phys                                                                                            |
| Division or Vital Records, P.O. Box 68760, | Attending                                                                                       |
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| _                                          | To the Hospital or Attending Physician: The law requires that the death certificate he executed |
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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 175              | Registrar  1. Decedent's Nam                                                                                           | ne (First, Middle, i                 | _ast)                                                                |                                    | 00                    | inicate or i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Deam                       | 2. Date of De                               |                             | UUU                               | 3. Time of Death                                   |
| Physici<br>/Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | -                | Christop                                                                                                               | her S. 1                             | Barwick                                                              |                                    |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            | Month<br>02-21-                             | Day<br>2008                 | Year                              | 1:00 AM                                            |
| Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | _                |                                                                                                                        |                                      | ive street and number)                                               |                                    |                       | 4b. City, Town, or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | r Location of D            | eath                                        | 4c. Cou                     | inty of Deat                      | h                                                  |
| Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | 5. Social Security                                                                                                     |                                      |                                                                      | e (In yrs. i                       | last birthday)        | If Under 1 Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | If Under 24                |                                             | th<br>V Year)               | 9. Birt                           | hplace (State or Foreign                           |
| Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | 220-50-03                                                                                                              |                                      | 1 🕅 M 2 🗆 F                                                          | 59                                 | Yrs.                  | Months Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Hours N                    | 07-12-1                                     |                             |                                   | yland                                              |
| ow at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | Usual Residence o<br>10a. State                                                                                        | 10b. County                          |                                                                      | 10c. City                          | y, Town or Lo         | ocation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                            |                                             |                             |                                   | 10d. Inside City Limits                            |
| Ba-f sh<br>tifled                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ctor             | Maryland                                                                                                               | Harf                                 | ord                                                                  | Al                                 | oerdee                | n                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                            |                                             |                             |                                   | 1 ∐Yes 27 No                                       |
| with th<br>a or 28<br>be no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Director         | 10e. Street and Nu 1926 F1e                                                                                            |                                      | ,                                                                    |                                    |                       | 10f. Zip Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                            |                                             | 10g. Citizen                |                                   | ountry?                                            |
| ms 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Funeral          | 1920 FIE                                                                                                               | etcher Ro                            | 12. Was Decedent                                                     | Ever in U.                         | S. 13.                | 21001<br>Was Decedent of H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                            | ? (Specify Yes or No<br>Puerto Rican, etc.) | U.S.                        | Race - Ame                        | rican Indian,                                      |
| after<br>or ite                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                        | ried 2 🔀 Married                     | If Yes, Give                                                         | No                                 |                       | ir yes, specify Cuba<br>1 ☐ Yes 2 【X No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | an, mexican, P  Specify:   | uerto Hican, etc.)                          |                             | Black, White<br>ec <i>ity:</i> Wh |                                                    |
| hours<br>ttural";<br>al Exe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ed by            | 3 🗌 Widowed                                                                                                            | 4 ☐ Divorced  15. Decedent's         | Year or Dates:                                                       |                                    | 0.00                  | dent's Usual Occup                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            |                                             |                             | of Business/                      |                                                    |
| hin 72<br>e.<br>an "na<br>Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Completed        | (Special Elementary/Second                                                                                             | cify only highest g                  | grade completed)  College (1-4or 5                                   | 5+)                                | (Give<br>life.        | kind of work done<br>DO NOT use retired                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | during most of<br>d)       | working                                     | 14                          |                                   | ·                                                  |
| led wil<br>hygien<br>her tha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                        |                                      | I                                                                    |                                    | Cont                  | ract Spec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                            | Name (First, Middle                         |                             |                                   | ov. Grounds                                        |
| d be fi<br>ental F<br>ked ot<br>c ever                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | To Be            | 17. Father's Name Henry Ba                                                                                             |                                      | SI)                                                                  |                                    |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            | y Thomas                                    | , waideri Suri              | name)                             |                                                    |
| shoul<br>and M<br>s mar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ۴                | 19a. Informant's N                                                                                                     |                                      | (Type. Print)                                                        |                                    | 19b. Maili            | ng Address (Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ·                          | or Rural Route Numb                         | er, City or To              | wn, State, 2                      | Zip Code)                                          |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injary or other traumatic event, the Medical Examiner must be notified at once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  | Susan Ba                                                                                                               |                                      | Vife)                                                                | 20h B                              |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            | berdeen M                                   |                             |                                   | Taura Chata                                        |
| ages ant of h                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                        | •                                    | ☐Removal from State                                                  |                                    |                       | osition (Name of<br>matory or other place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ' 0.0                      | 2-26-2008                                   |                             | ,                                 | Town, State                                        |
| mit. P<br>partme<br>portan<br>y injur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | 21. Signature of F                                                                                                     |                                      |                                                                      | Day                                |                       | Crematory<br>2. Name and Addre                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ee of Encility             |                                             |                             | imore,                            | ne of BelAir                                       |
| Depar<br>Important in any in once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | P                                                                                                                      | ano.                                 | Grac                                                                 | 2                                  | I                     | nc. 610 W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | . MacP                     | hail Rd B                                   | el Air                      | , MD 2                            | 21014                                              |
| Physician<br>/Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | 23a. Part1. Enter<br>shock, or hea<br>Immediate Cause<br>disease or condition<br>resulting in death)                   | art failure. List or<br>(Final<br>on | mplications that caused by one cause on each line.  a. Due to (or as | aru                                | RH                    | ter the mode of dyin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | such as ca                 | rdiac or respiratory a                      | ırrest,                     |                                   | Approximate<br>Interval Between<br>Onset and Death |
| eath certificate be executed the standing physician and tor use as the burial-transit to the standing physician and the standing physician and the standing physician are standing to the standing physician are standing physician and the standing physician are standing physician and standing physician are standing physici | cal Examiner     | Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) | S 📰                                  | b                                                                    |                                    |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |                                             |                             |                                   |                                                    |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Physician/Medica | IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown                                                       | 2 months?                            | 23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown        | 2 ☐ Feta                           | I death 3             | □Ectopic pregnancy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | у                          |                                             | 23d.                        | Date of del                       | livery<br>Day Year                                 |
| es tha<br>gned b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | by P             | Part II. Other signi                                                                                                   | ificant condition                    | s contributing to death b                                            | ut not resu                        | ulting in the u       | nderlying cause giv                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | en in Part I.              |                                             |                             |                                   | the cause of death?                                |
| requir<br>been si<br>hould                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | eted             | DICLOST                                                                                                                |                                      |                                                                      |                                    |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |                                             | Yes 2 N                     |                                   |                                                    |
| n: The law<br>ificate has b<br>or, page 2 s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Completed        | 25. Was case refe                                                                                                      | wrod to medical                      |                                                                      | _                                  |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | On Diagram                 | 24a. Was auto perfu                         | psy<br>ormed?<br>2 No       |                                   | utopsy findings available completion of cause of   |
| nysicia<br>nis cert<br>direct                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | To Be            | examiner?                                                                                                              | <b>K</b> No                          | Hospital: 1   Inpatie                                                | ent 2 🗌                            | ER/Outpatie           | nt 3 DOA Oth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                            |                                             | idence 6 🗆                  | Other (Spe                        | cify)                                              |
| ding Pt<br>h.<br>After th<br>funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ion:             | 27. Manner of Dea                                                                                                      | ith<br>5                             | 28a. Date of Inju<br>(Month, Da                                      |                                    | 28b. Time o<br>Injury | Wor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ryat<br>rk?<br>Yes 2∐No    | 28d. Describe                               | how injury oc               | ccurred                           |                                                    |
| To the Hospital or Attending Physician: The Is within 24 Hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Certification:   | 2 ☐ Accident<br>3 ☐ Suicide<br>4 ☐ Homicide                                                                            | 6 Could not<br>determine             | be 280 Place of ini                                                  | ury - At ho<br>c. <i>(Specif</i> y | ome, farm, st<br>y)   | reet, factory, office                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                            | 28f. Location (                             | Street and Ni<br>wn, State) | umber or Ri                       | ural Route Number,                                 |
| e Hospit<br>24 hour<br>e Funer<br>etely fill                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Medical (        | 29a. Certifier<br>(Check only<br>one)                                                                                  |                                      | Physician: To the best<br>aminer: On the basis of<br>and manner st   | f examina                          |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |                                             |                             |                                   |                                                    |
| <b>To th</b> within <b>To th</b> Comp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Me               | 29b. Signature and                                                                                                     | d title of certifier                 | a Mi                                                                 | 5                                  |                       | 29c. Licens                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | se number<br>)438 <i>2</i> | 15                                          | 29d. Date si                | gned (Mont                        | th, Day, Year)                                     |
| 20                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 30. Name and add                                                                                                       | Har.M.                               | o completed cause of c                                               | rulo                               | 1 23a) (Type,         | Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Sust                       | em Pers                                     | u Poi                       | at.m                              | 1D 21902                                           |
| Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 31. Date filed (Mor                                                                                                    |                                      | 32. Registr                                                          | ar's Signa                         | ture                  | 6"                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | J                          | - 11-5                                      | J                           |                                   |                                                    |
| Registr<br>MH 17 Rev 1/2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                        | 1 _ 0 %                              | 8 2008                                                               | 1000                               | 1                     | A STATE OF THE PARTY OF THE PAR |                            |                                             | -                           |                                   |                                                    |

Division or Vital Records, P.O. Box 68760,

| Nancy J. Bromwell  A Results Name (if not institution, you stored and number)  A Results Name (if not institution, you stored and number)  A Results Name (if not institution, you stored and number)  A Results Name (if not institution, you stored and number)  A Results Name (if not institution, you stored and number)  A Results Name (if not institution, you stored and number)  A Results Name (if not institution, you stored and number)  A Results Name (if not institution, you stored and number)  A Results Name (if not institution, you stored and number)  B altimore  10 Results Name (if not institution, you stored and number)  10 Results Name (if not institution, you stored and number)  10 Results Name (if not institution, you stored and number)  10 Results Name (if not institution, you stored and number)  10 Results Name (if not institution, you stored and number)  10 Results Name (if not institution)  10 Results Name (if not instit |                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| As Facility Name (if not institution, page steed and number)  46. City, Town, or Location of Death  47. City Town, or Location of Death  48. Coursy of Death  49. Coursy Obes  49. Coursy Obes  49. Coursy Name  21.5-66-22.72  10.M 28/F 48 yrs.  21.5-66-22.72  10.M 28/F 58 yrs.  10.C city, Town or Location  10.S price of State of Coursy or State of St | . Time of Death                |
| Social Security Number   G. Sax and Bink   State   S   | L. 30 a                        |
| Baltimore   10c. Steve   10c. College   10c. Steve   10   | e (State or Forei              |
| MD   Baltimore   Baltimore   10. Zip Code   10. Citizen of What Country?   10. Wise Lipschedent Even in U.S.   12. Wise Lipschedent Even in U.S.   13. Wise Description (Figure 200 No. Specify): What is the Color of Part of Education (Figure 200 No. Specify): What is the Color of Part of Education (Figure 200 No. Specify): White Specify only highest educ completed)   150. Description (Figure 200 No. Specify): White Specify only highest educ completed)   150. Description (Figure 200 No. Specify): White Specify: Wh   | Inside City Limi               |
| 18                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1 □Yes 2 v N                   |
| Securitially list conditions   Securitial   Securitian    | ?                              |
| 11. Marmal Status                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                |
| James Cox    James Cox   Securior   Securior |                                |
| James Cox    Sa. Informant's Namon-Relationship (Type. Print)   19b. Mailing Address (Sineal and Number or Rural Route Number, City or Town, Slate, Zip Code, 64 King Henry Circle Baltimore MD 21237    20b. Mailing Address (Sineal and Number or Rural Route Number, City or Town, Slate, Zip Code, 64 King Henry Circle Baltimore MD 21237   20b. Mailing Address (Sineal and Number or Rural Route Number, City or Town, Slate, Zip Code, 64 King Henry Circle Baltimore MD 21237   20b. Place of Disposition (Namor of coder place)   Date   20b. Location - City or Town. Standard City or Coder place)   Cardens of Faith   02–28–2008   Baltimore MD   21. Signappro of Faith   02–28–2008   Baltimore MD   21. Signappro of Faith   02–28–2008   Baltimore MD   21. Signappro of Faith   02–28–2008   Baltimore MD   27. Shate man and Address of Radilly Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21236   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD 21 | try                            |
| James Cox    James Cox   19b. Mailing Address (Sireat and Number or Plural Route Number, City or Town, State, Zip Code, 64 King Henry Circle   Baltimore MD 21237   20b. Place of Disposition (Name of Order Place)   19b. Mailing Address (Sireat and Number or Plural Route Number, City or Town, State, Zip Code, 64 King Henry Circle   Baltimore MD 21237   20b. Place of Disposition (Name of Order Place)   19b. Mailing Address (Sireat and Number or Plural Route Number, City or Town, State, Zip Code, 64 King Henry Circle   Baltimore MD 21237   20b. Place of Disposition (Name of Order Place)   19b. Mailing Address (Sireat and Number or Plural Route Number, City or Town, State, Zip Code, 64 King Henry Circle   Baltimore MD 21236   20b. Place of Disposition (Name of Order Place)   19b. Mailing Address (Sireat and Number or Plural Route Number, City or Town, State, Zip Code, 64 King Henry Circle   Baltimore MD 21236   21b. Maname and Address of Patith   02–28–2008   Baltimore MD 21236   22b. Maname and Address Family   19b. Mailing Address (Sireat and Number or Plural Route Number, City or Town, State, 21b. Code, 19b. Mailing Address (Sireat and Number or Plural Route Number, City or Town, State, 21b. Code, 19b. Mailing Address (Sireat and Number or Plural Route Number, City or Town, State, 21b. Code, 19b. Mailing Address (Sireat and Number or Plural Route Number, City or Town, State, 21b. Code, 19b. Mailing Address (Sireat and Number or Plural Route Number, City or Town, State, 21b. Code, 19b. Mailing Address (Sireat and Number or Plural Route Number, City or Town, State, 21b. Code, 19b. Mailing Address (Sireat and Number or Plural Route Number, City or Town, State, 21b. Code, 19b. Mailing Address (Sireat and Number or Plural Route Number, City or Town, State, 21b. Code, 19b. Mailing, 21b. Mailing, 21b | Service                        |
| James Cox   Margaret M. McKay   19a. Informant's Name/Relationship (Type Print)   19b. Mailing Address (Street and Number or Burail Bound Number. (If yor Town, State, Zip Code, 19a. Informant's Name/Relationship (Type Print)   19b. Mailing Address (Street and Number or Burail Bound Number or Town, State, Zip Code, 19b. Mailing Address (Street and Number or Burail Bound Number or Town, State, Zip Code, 19b. Mailing Address (Street and Number or Burail Bound Number or Burail Flow.   19b. Mailing Address (Street and Number or Burail Bound Number or Burail Bound Number or Burail Bound Number or Burail Bound Number or Burail Flow.   19b. Mailing Address of Facility     | JCI VICE                       |
| 198_Informent's Name/Relationship (Type Print)   198. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code, 64 King Henry Circle Baltimore MD 21237   20a. Method of Disposition   128 Burial 2   Cremation 3   Removal from State   20b. Place of Disposition (Name of Certificity, Crimabloly or other place)   20b. Date   20c. Location - City or Town, State   20c. Deaten - City or Town, St.   20c. Deaten - City or   |                                |
| 20s. Method of Disposition  1 2 Source Coloremation   20s Please of Disposition (Name of Cemberlay, Colorematory or Chemetary Chemet | ide)                           |
| 13 Surial   2   Cremation   3   Removal from State   4   Donation   5   Other (specify)   21. Signature of Funeral Service Licensee   22. Name and Address of Facility   Schimunek Funeral Home   9705 Belair Rd   Nottingham MD   21236                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                |
| Due to (or as a consequence of):    Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | e Inc.                         |
| 1   Yes   2   No   3   Probably                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |
| 1   Yes   2   No   3   Probably                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ay Year                        |
| 25. Was case referred to medical examiner? 1   Yes 2   No  1   Yes 2   No  26. Place of Death (Check only one)  27. Manner of Death 1   Natural 2   Accident 3   DoA  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M 1   Yes 2   No  28c. Injury at Work? 4   Nursing Home 5   Residence 6   Other (Specify)  28d. Describe how injury occurred Work? 4   Homicide  28d. Describe how injury occurred  28d. Describe how injury occurr |                                |
| Top   Position   Pos   | letion of cause of             |
| 27. Manner of Death   Manner o |                                |
| 29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Certifier 29d. Certifier 29d. Date signed (Month, Day, Vision of the cause (s) and manner as stated. 29d. Date signed (Month, Day, Vision of the cause (s) and manner as stated. 29d. Date signed (Month, Day, Vision of the cause (s) and manner as stated. 29d. Date signed (Month, Day, Vision of the cause (s) and manner as stated. 29d. Date signed (Month, Day, Vision of the cause (s) and manner as stated. 29d. Date signed (Month, Day, Vision of the cause (s) and manner as stated. 29d. Date signed (Month, Day, Vision of the cause (s) and manner as stated. 29d. Date signed (Month, Day, Vision of the cause (s) and manner as stated. 29d. Date signed (Month, Day, Vision of the cause (s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                |
| 29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29a. Certifier (Check only one)  29d. Date signed (Month, Day, Vision of the cause)  29d. Date signed (Month, Day, Vision of the cause)  29d. Date signed (Month, Day, Vision of the cause)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Route Number,                  |
| 1 h m mm 1 h n m                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ed.                            |
| 3. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANNA MAKIA IZQUIERDO-PORREKA 9000 Franklin Square dive Balto.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ed.<br>ne cause(s)<br>y, Year) |
| ANNA MAKIA IZQUIERDO-PORREKA 9000 Franklin Square dive Balto.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ed.<br>ne cause(s)<br>y, Year) |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear **Physician** 1:30 PM Virginia P. Belew February 21 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Nursing Itome Harford Havie De Groce 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□M 2√X 83 Maryland 216-28-4657 Director Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Director Maryland Harford Havre de Grace 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or ? must be n 415 S. Market St. 21078 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or Item edical Examiner Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed er than "natur the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 Is marked other than "other traumatic event, the Mea Elementary/Secondary (0-12) College (1-4or 5+) 12th House wife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jefferson Gover Mabel Hanna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7817 Locust Wood Rd. Severn, Maryland 21144 Floyd Belew, Sr. permit. Pages 1 and Department of Health Important: If item 27 any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐RemovaLfrom State Holly Hill Memorial 2/26/2008 Middle River, Maryland 4 □ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one equition each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician welmhind /Medical of e to (or as a consequence of): J-Ment W Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part In Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by memile 2 Medical Certification: To 2

Examiner Box 68760. P.O. Records, Vital Physician:

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Hospital or Attending

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

n 24 hours after death.

The Funeral Director: Af oletely filled in by the fulloner for the fulloner for the fulloner for the fulloner ful

| _  | His LO Ist . o                                |                                   |                                                                                        |                                           |                        |   |      |                               |               |                                                                                 | Times Zimo Simple Probably 4 parknow                                                             | 11 |  |
|----|-----------------------------------------------|-----------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------|------------------------|---|------|-------------------------------|---------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|----|--|
|    |                                               |                                   |                                                                                        |                                           |                        |   |      |                               |               |                                                                                 | 24a. Was an autopsy findings availab prior to completion of cause of death?  1 ☐ Yes 2 ☐ No      |    |  |
| 5. | Was case refer                                | red to medical                    |                                                                                        |                                           |                        |   |      | 26.                           | Place of Deat | h (C                                                                            | Check only one)                                                                                  |    |  |
|    | examiner?<br>1 ☐ Yes 2 D                      | No                                | Hospital:                                                                              | : 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA |                        |   |      |                               | Nursing Ho    | ome                                                                             | 5 ☐ Residence 6 ☐ Other (Specify)                                                                |    |  |
| 7. | Manyer of Deat<br>1 ☑ Natural<br>2 ☐ Accident | h<br>5 □ Pending<br>investigation |                                                                                        | Date of Injury<br>(Month, Day Year)       | 28b. Time of<br>Injury | М | 28c. | Injury at<br>Work?<br>1 ☐ Yes | 2 🗆 No        | 28d                                                                             | d. Describe how injury occurred                                                                  |    |  |
|    | 3 ☐ Suicide<br>4 ☐ Homicide                   | 6 Could not be determined         | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |                                           |                        |   |      |                               |               | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                                                                                  |    |  |
| 29 | a. Certifier<br>(Check only<br>one)           |                                   | miner: On                                                                              |                                           |                        |   |      |                               |               |                                                                                 | d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) |    |  |

29b. Signature and title of certifier

31. Date filed (Nonth, Day, Year FEB 2 8

M.n.

2. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year) 0

State

of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address (M) on

9,m

2008

onb

Registrar

within 2 To the I

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 1   | For<br>State<br>Registrar                                                                                                                                    |                       | State of Ma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | arylan          |                                                                                                                                                                                                  | artment of I<br>rtificate of                                        |                             | and Mei              |                                         | iene<br><sub>eg. No.</sub> 2 ()   | 08                                     | 06128                                              |
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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ician<br>dical   | 1   | 1. Decedent's Name (F                                                                                                                                        | First, Middle,        | Bowen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                 |                                                                                                                                                                                                  |                                                                     |                             |                      | Date of Deat<br>Month                   | th<br>Day                         | Year                                   | 3. Time of Death                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | niner            | 4   |                                                                                                                                                              | <b>2-WA</b> 9         | give street and number) <b>LANCTON MCS</b> 6. Sex  1 □ M 2 N F  7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | e (In yrs.      | LENTER<br>last birthday)<br>Yrs.                                                                                                                                                                 | 4b. City, Town, of CLEN R  If Under 1 Year  Months Days             | If Under                    | of Death  24 Hrs. 8. | Date of Birth<br>(Month, Day,<br>UNE 7, | 4c. County                        | of Death<br>ARU<br>9. Birth<br>Cou     | DUDEC  Splace (State or Foreign untry)  VIRGINIA   |
| D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2-46-            |     | Usual Residence of De                                                                                                                                        | ecedent<br>0b. County |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 10c. City       | y, Town or Lo                                                                                                                                                                                    |                                                                     |                             | J                    | UNE 7,                                  | WEST                              | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No |                                                    |
| eath with the is 23a or 28 must be no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Funeral Director |     | 10e. Street and Number 102 EMERSO                                                                                                                            |                       | 12. Was Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Ever in II      | S 13 V                                                                                                                                                                                           | 10f. Zip Code<br>21061                                              | Hispanic Or                 | igin? (Specit        | 1                                       | 0g. Citizen of UNITED             | STAT                                   |                                                    |
| ours after d<br>rral", or item<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | by Fig           | 2   | 1 ☐ Never Married 3 ☐ Widowed 4                                                                                                                              |                       | Armed Forces?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                 |                                                                                                                                                                                                  | Was Decedent of I<br>f Yes, specify Cub<br>1 □ Yes 2ሺ No            |                             |                      | an, etc.)                               | Bla                               | ck, White                              | , etc.                                             |
| If it is in the Maryland filed within 72 hours after death with the Maryland Hygiene.  Hygiene.  Hydre than "natural", or items 23a or 28a-f show ther than decical Examiner must be notified at snt, the Medical Examiner must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Completed        | -   | (Specify<br>Elementary/Seconds                                                                                                                               |                       | s Education<br>grade completed)<br>College (1-4or 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | i+)             | 16a. Deced<br>(Give<br>life. I<br>HOMEM                                                                                                                                                          | dent's Usual Occu<br>kind of work done<br>DO NOT use retire<br>AKER | pation<br>during mos<br>ed) | t of working         |                                         | 16b. Kind of B                    |                                        | ndustry                                            |
| 2 should be filed with and Mental Hygiene. Is marked other than aumatic event, the N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | To Be            | 3   | 17. Father's Name (Fin                                                                                                                                       |                       | ast)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                 |                                                                                                                                                                                                  |                                                                     |                             | ·                    | irst, Middle, M                         | Maiden Surnar                     | ne)                                    |                                                    |
| is 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene.  The strong and Mental Hygiene.  The strong and the than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |     | 19a. Informant's Name WILLIAM H 20a. Method of Dispos                                                                                                        | BOWE                  | ZN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 20b. F          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 102 EMERSON AVE., GLEN BURNIE, MARY)  20b. Place of Disposition (Name of cemetery, crematory or other place)  FER 29 |                                                                     |                             |                      |                                         |                                   |                                        |                                                    |
| permit. Pages 1 and 2 Department of Health a Important: If item 27 is                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | once.            |     | 1                                                                                                                                                            | Other (Sp.            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 | RDENS C                                                                                                                                                                                          | F FAITH                                                             | CEM.                        | FEB. 2<br>2008       | I                                       |                                   |                                        | MARYLAND                                           |
| Physicia /Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | in               |     | 23a. Part1. Enter the shock, or heart f. Immediate Cause (Fin disease or condition resulting in death)                                                       | fallure. List o       | complications that caused inly one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ne.             | h. Do not ent                                                                                                                                                                                    |                                                                     |                             |                      |                                         |                                   |                                        | 21061 Approximate Interval Between Onset and Death |
| be executed be executed burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | eal Examiner     | 100 | Sequentially list condi-<br>ir any Learning to inni-<br>cause. Enter Underlyi<br>Cause (Disease or inji-<br>that initiated events<br>resulting in death) Las |                       | b. Due to (or as  c. Due to (or as  d.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | LRY<br>a conseq | TRAC                                                                                                                                                                                             | t ihee                                                              | 10172                       | <b>S</b>             |                                         |                                   |                                        | JMEEK?                                             |
| The law requires that the death certificate I are has been signed by the attending physicage 2 should be detached for use as the teached | Physician/Medi   |     | IF FEMALE:<br>23b. Was decedent pr<br>in the past 12 mo<br>1 ☐ Yes 2 ☐ N<br>9 ☐ Unknown                                                                      | Ectopic pregnanc      | ey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                 |                                                                                                                                                                                                  |                                                                     | ite of delivers             | very<br>Day Year     |                                         |                                   |                                        |                                                    |
| w requires that the d<br>been signed by the<br>should be detached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2                | 2   | Part II. Other significa                                                                                                                                     | ant condition         | ns contributing to death b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ut not res      | ulting in the ui                                                                                                                                                                                 | nderlying cause gi                                                  | ven in Part I               | ———                  | 1 □ Ye                                  | es 2 No                           | tribute to<br>3 ☐ Pro                  | the cause of death?  bbably 4 □Unknown             |
| Physiclan; The law this certificate has build director, page 2 s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Completed        |     | 25. Was case referred                                                                                                                                        | d to madical          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                                                                                                                                                                                  |                                                                     | 00 Plan                     | of Dooth (           |                                         | med?<br>2 No                      | Were aut prior to c death?             | topsy findings available ompletion of cause of     |
| rsicla<br>s cert<br>lirecto                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | G Be             | )   | examiner?<br>1 ☐ Yes 2 🔀 No                                                                                                                                  |                       | Hospital:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | nt 2□           | ER/Outpatien                                                                                                                                                                                     | t 3 DOA Ot                                                          | her                         |                      | heck only on                            | <i>e)</i><br>ence 6 ⊟Otl          | or (Coo                                |                                                    |
| . o <u>a</u> a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 10  | 27. Manner of Death 1 Natural 2  Accident                                                                                                                    | 5 ☐ Pending investiga | 28a. Date of Inju                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ry<br>y Year)   | 28b. Time of<br>Injury                                                                                                                                                                           | 28c. Inju<br>Wo<br>M 1                                              |                             | No 280               | l. Describe ho                          | ow injury occur                   | red                                    |                                                    |
| To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | al Certifi       |     | 4 ☐ Homicide  29a. Certifier 1                                                                                                                               | determin              | building, etc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | of my kno       | wledge, deatl                                                                                                                                                                                    | eet, factory, office                                                | ime, date ar                | nd place, and        | City or Town                            | n, State) ause(s) and m           | anner as                               | ral Route Number,                                  |
| To the Ho<br>within 24 f<br>To the Fu<br>completely                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Medical          |     | one)<br>29b. Signature and title                                                                                                                             | le of certifier       | xaminer: On the basis of<br>and manner sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ated.           | tion and/or in                                                                                                                                                                                   | vestigation, in my                                                  |                             | ath occurred         |                                         | late and place,<br>9d. Date signe |                                        |                                                    |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |     | 30. Name and address                                                                                                                                         | s of person w         | the County out of de County of the County of | eath (Item      | n 23a) (Type.                                                                                                                                                                                    | Print)                                                              | e7±1                        |                      |                                         |                                   |                                        | 56,5008                                            |

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, 'Year)

32. Registrar's Signature

08-01566 Joseph Anthony Barilla

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| oseph Anthony B                                                                                                                                                                                                                                                                                                                          |                         | State of Maryland / Department of Health and Ment<br>For State Certificate of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | tal Hygien                                                                      | e<br>Reg. No           | 20                            | 08 0612                                                |  |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------|-------------------------------|--------------------------------------------------------|--|--|--|--|
| Physician                                                                                                                                                                                                                                                                                                                                |                         | egistrar<br>Decedent's Name (First, Middle,Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                 | of Death               |                               | 3. Time of Death                                       |  |  |  |  |
| Medical Examine                                                                                                                                                                                                                                                                                                                          |                         | JOSEPH ANTHONY BARILLA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Febr                                                                            | uary 23, 2             | 2008                          | 2120 hrs                                               |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                          | 4                       | a. Facility Name (if not institution, give sirest and its institution)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death Pasadena  4c. County of Death Anne Arundel |                        |                               |                                                        |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                          |                         | 1920 East Ellu Dilve                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | er 24Hrs. 8. Da                                                                 | te of Birth (M         | M/DD/YYYY) 9. Bir             |                                                        |  |  |  |  |
| Funeral                                                                                                                                                                                                                                                                                                                                  | 5                       | Months Days Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Forei                                                                           |                        |                               |                                                        |  |  |  |  |
| Director                                                                                                                                                                                                                                                                                                                                 |                         | 213-80-1707   1XM 2 F 48 Yrs.   White State   48 Yrs.   1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1939                                                                            | TIAKT LAND             |                               |                                                        |  |  |  |  |
| any                                                                                                                                                                                                                                                                                                                                      | _                       | Sual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                 |                        |                               | 10d. Inside City Limits                                |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                          |                         | MARYLAND ANNE ARUNDEL CROFTON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                 |                        |                               | 1 Yes 2 X No                                           |  |  |  |  |
| faryland                                                                                                                                                                                                                                                                                                                                 | 밁                       | 0e. Street and Number 10f. Zip Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                 | 10g. 0                 | Citizen of What Cou           | intry?                                                 |  |  |  |  |
| he Mz                                                                                                                                                                                                                                                                                                                                    | Director                | 2349 DARTMOUTH LANE 21114                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                 | UN                     | ITED STAT                     |                                                        |  |  |  |  |
| death with the Maryland or items 23a or 28a-f sho                                                                                                                                                                                                                                                                                        |                         | 1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | igin? (Specify Yen, Puerto Rican,                                               | es or No-<br>etc.)     | 14. Race - Ame<br>White, etc. | rican Indian, Black,                                   |  |  |  |  |
| death death                                                                                                                                                                                                                                                                                                                              | Funeral                 | 1 Never Married 2 Married 1 Yes 2 X No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                 |                        | Specify: WH                   | ITE                                                    |  |  |  |  |
| after                                                                                                                                                                                                                                                                                                                                    | <u>a</u> _              | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify only highest grade completed) 16a. Decedent's Usual Occupation (Give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                 | ne 16                  | b, Kind of Business           |                                                        |  |  |  |  |
| hours<br>'natu                                                                                                                                                                                                                                                                                                                           |                         | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | T use retired)                                                                  |                        |                               |                                                        |  |  |  |  |
| 36<br>nin 72<br>E. Ihan '                                                                                                                                                                                                                                                                                                                | <u>e</u>                | 12 GROCERY CLERK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                 |                        | GROGERY                       | STORE                                                  |  |  |  |  |
| d with                                                                                                                                                                                                                                                                                                                                   | Completed               | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | er's Name (First,                                                               |                        |                               |                                                        |  |  |  |  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than                                                                                                                                                                                                                                                                       | 8                       | FRANK JUSEIII DARIEDIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | UELINE                                                                          | MARIE                  | HAYES                         | te. Zin Code)                                          |  |  |  |  |
| 21<br>hould<br>hould Me<br>is ma                                                                                                                                                                                                                                                                                                         | <del>ို</del>           | 7,7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | NE. CRO                                                                         | FTON.                  | MARYLAND                      | 21114                                                  |  |  |  |  |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once                     | -                       | FRANK D. BARILLA / BROTHER 2349 DARTMOUTH LA  20a. Method of Disposition (Name of cemetery,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Date                                                                            | 20                     | 0c. Location - City           | or Town, State                                         |  |  |  |  |
| Baltimore,<br>permit. Pages I ar<br>pepartment of Hee<br>Important: If ite                                                                                                                                                                                                                                                               | - 1                     | 1 Burial 2 X Cremation 3 Removal from State crematory or other place)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | FEB.<br>2008                                                                    | $^{27},$               | CATONSVIL                     | LE, MARYLAND                                           |  |  |  |  |
| tim<br>t. Pag<br>tment<br>rtant:                                                                                                                                                                                                                                                                                                         | 1                       | 4 \    Donation 5 \  Other Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | lity                                                                            |                        |                               |                                                        |  |  |  |  |
| Balt<br>permit.<br>Departu<br>Importi<br>injury                                                                                                                                                                                                                                                                                          | - 1                     | 1421 CRAIN HWY.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | . S.E.,                                                                         | GLEN                   |                               | MD 21061                                               |  |  |  |  |
| Physician                                                                                                                                                                                                                                                                                                                                | $\dashv$                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | cardiac or respi                                                                | ratory arrest,         | shock, or heart               | Approximate Interval<br>Between Onset and              |  |  |  |  |
| Medical                                                                                                                                                                                                                                                                                                                                  |                         | failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                 |                        |                               | Death                                                  |  |  |  |  |
| aminer                                                                                                                                                                                                                                                                                                                                   |                         | or condition resulting in death)  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                 |                        |                               |                                                        |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                          | ١,                      | Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                 |                        |                               |                                                        |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                          | Ē                       | cause. Enter Uniterlying Cause c.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                 |                        |                               |                                                        |  |  |  |  |
| ₩ 8 ×                                                                                                                                                                                                                                                                                                                                    | Examiner                | events resulting in death) Last Due to (or as a consequence or).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                 |                        |                               |                                                        |  |  |  |  |
| e be executed ysician and burial - transit                                                                                                                                                                                                                                                                                               | edical                  | MFNRED AMFNRED 27 porMF c877 3/3/08 TT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                 |                        |                               |                                                        |  |  |  |  |
| 30,<br>te be e<br>nysicia                                                                                                                                                                                                                                                                                                                | ledi                    | IF FEMALE: 23c. If yes, outcome of pregnancy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                 |                        | 23d. Date of deliv            |                                                        |  |  |  |  |
| Box 6876C<br>e death certificate be<br>the attending physed for use as the b                                                                                                                                                                                                                                                             | Physician/M             | 23b. Was decedent pregnant in the past 12 months?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | opic pregnancy                                                                  |                        | Month                         | Day Year                                               |  |  |  |  |
| OX 6                                                                                                                                                                                                                                                                                                                                     | sici                    | 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                 |                        |                               |                                                        |  |  |  |  |
| b. B. the de ched f                                                                                                                                                                                                                                                                                                                      | 된                       | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Part I.                                                                         |                        | _                             | to the cause of death?                                 |  |  |  |  |
| ords, P.O. B w requires that the d is been signed by the                                                                                                                                                                                                                                                                                 | <u>ā</u>                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                 | 1 Yes                  |                               | Probably 4 V Unknown                                   |  |  |  |  |
| ds,                                                                                                                                                                                                                                                                                                                                      | etec                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                 | 24a. Was an<br>autopsy | / prior                       | e autopsy findings available to completion of cause of |  |  |  |  |
| cords the faw require that been ge 2 should                                                                                                                                                                                                                                                                                              | Completed               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                 | perform<br>Yes 2       |                               |                                                        |  |  |  |  |
| tal Reccian: The certificate                                                                                                                                                                                                                                                                                                             |                         | 25. Was case reierred to medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ath (Check only o                                                               |                        |                               |                                                        |  |  |  |  |
| Vita<br>ysician<br>his cer<br>direct                                                                                                                                                                                                                                                                                                     | o Be                    | examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | - ttoromig ris                                                                  |                        | esidence 6 🗸 C                | ther: Scene                                            |  |  |  |  |
| of Vil<br>ing Physican After this                                                                                                                                                                                                                                                                                                        |                         | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                 | . Describe ho          | ow injury occurred            |                                                        |  |  |  |  |
| ion<br>tendii<br>tor: A                                                                                                                                                                                                                                                                                                                  | atio                    | 1 X Natural 5 Pending 2 Accident Investigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                 | Landian (Ct            | reet and Number o             | r Rural Route Number, City                             |  |  |  |  |
| Division of Vital Records, tall or Attending Physician: The law requiring and earlier and a state death.  The law requiring the state of the state of the funeral director, page 2 should the funeral director, page 2 should                                                                                                            | Certification:          | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | g, etc. 201.                                                                    | or Town, Sta           |                               | Trains (today trained), etty                           |  |  |  |  |
| Spital<br>spital<br>neral<br>filled                                                                                                                                                                                                                                                                                                      | Cer                     | 4 Homicide determined (Specify)  29a. Certifier 1 Continue Physician: To the hest of my knowledge, death occurred at the time, date and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | i place and due                                                                 | to the cause           | (s) and manner as             | stated.                                                |  |  |  |  |
| Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b | 27. Manner of Death   1 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                 |                        |                               |                                                        |  |  |  |  |
| To t<br>with<br>To t                                                                                                                                                                                                                                                                                                                     | Med                     | and manner stated.  29c. License number 1. 20c. License number 1. 20 |                                                                                 | 29d. Date signed       |                               |                                                        |  |  |  |  |
| DA WA                                                                                                                                                                                                                                                                                                                                    | 8                       | M. h. m. D. O.C.M.E.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | O.C.M.E. February 24, 2008                                                      |                        |                               |                                                        |  |  |  |  |
| n with                                                                                                                                                                                                                                                                                                                                   |                         | 30. Name and address of person who completed cause of death (Item 23a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                 |                        |                               |                                                        |  |  |  |  |
| 300                                                                                                                                                                                                                                                                                                                                      |                         | Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 21201                                                                           |                        |                               |                                                        |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                          | tate                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                 |                        |                               |                                                        |  |  |  |  |
| Regis                                                                                                                                                                                                                                                                                                                                    | trar                    | FFB 2 8 2008   Marie 18 19 19 19 19 19 19 19 19 19 19 19 19 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                 |                        |                               |                                                        |  |  |  |  |

|                                                                                                                                                                                                                                                                                                          |                                |                                                                                                                                     | Plea                               |                                         |                              |                                       |                      | ndelible Ink<br>partment of F                 |                                           | -                                    |                       | _                          |                                  |                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------|------------------------------|---------------------------------------|----------------------|-----------------------------------------------|-------------------------------------------|--------------------------------------|-----------------------|----------------------------|----------------------------------|------------------------------|
|                                                                                                                                                                                                                                                                                                          |                                | for<br>State<br>Registrar                                                                                                           |                                    |                                         | riate of f                   | viaiyiai                              |                      | ertificate of                                 |                                           | vicinairi                            | Reg. No               | 000                        | 3 04                             | 128                          |
|                                                                                                                                                                                                                                                                                                          |                                | Decedent's Nam                                                                                                                      | ne (First, Middi                   | le, Last)                               |                              |                                       |                      |                                               |                                           | 2. Date of D                         | eath                  | 1. 0.0                     |                                  | e of Death                   |
| Physicia<br>/Medic                                                                                                                                                                                                                                                                                       |                                | SAMUEI                                                                                                                              | L                                  |                                         |                              | BAK                                   | ŒR                   |                                               |                                           | Month<br>C 2                         | 2 s                   | -                          |                                  | 00 A M                       |
| Examin                                                                                                                                                                                                                                                                                                   |                                | 4a. Facility Name (                                                                                                                 | If not institutio                  | n, give stre                            | et and numbe                 | er)                                   |                      |                                               | or Location of Death                      | 1                                    |                       | c. County of De            |                                  |                              |
|                                                                                                                                                                                                                                                                                                          |                                | FRANKLIN                                                                                                                            |                                    | e Ho                                    |                              |                                       |                      | Rosed                                         |                                           | 1.5                                  |                       | Balti                      |                                  |                              |
| Funeral<br>Director                                                                                                                                                                                                                                                                                      |                                | 5. Social Security N<br>218-03-00<br>Usual Residence o                                                                              | 023                                | 6. Sex<br>1 🔀 M                         | 2□ F 7.                      | Age (In yrs.                          | last birthda<br>Yrs. | y) If Under 1 Year<br>Months Days             | If Under 24 Hrs. Hours Min.               | 8. Date of Bi<br>(Month, D<br>07/26/ | ay, Year              | ) (                        | irthplace (Sta<br>Country)<br>MD | te or Foreign                |
| /land<br>ow<br>at                                                                                                                                                                                                                                                                                        |                                | 10a. State                                                                                                                          | 10b. County                        | ,                                       |                              | 10c. Ci                               | ty, Town or          | Location                                      |                                           |                                      |                       |                            | 10d. Inside                      | City Limits                  |
| Man<br>a-f sh<br>ified                                                                                                                                                                                                                                                                                   | ctor                           | MD                                                                                                                                  | BAL                                | TIMOR                                   | RE                           |                                       | M                    | IDDLE RIV                                     | ER                                        |                                      |                       |                            | 1 🗆 \                            | ∕es 2∭ No                    |
| or 28                                                                                                                                                                                                                                                                                                    | Director                       | 10e. Street and Nu                                                                                                                  | ımber                              |                                         |                              |                                       |                      | 10f. Zip Code                                 |                                           |                                      | 10g. C                | itizen of What (           | Country?                         |                              |
| ath w                                                                                                                                                                                                                                                                                                    | ral                            | 2205 BAKER AVENUE                                                                                                                   |                                    |                                         |                              |                                       |                      |                                               | 21220                                     |                                      |                       | USA                        |                                  |                              |
| er de<br>items<br>ner m                                                                                                                                                                                                                                                                                  | by Funeral                     | 11. Marital Status                                                                                                                  | ried OF Mor                        |                                         | Was Decede                   | s?                                    | I.S. 13              | B. Was Decedent of F<br>If Yes, specify Cub   | Hispanic Origin? (S<br>an, Mexican, Puert | pecify Yes or N<br>o Rican, etc.)    | 0-                    | 14. Race - An<br>Black, Wh |                                  | ,                            |
| rs aft<br>I', or<br>xami                                                                                                                                                                                                                                                                                 |                                | 1 ☐ Never Married 2 ☐ Married 1 M Yes 2 ☐ N If Yes, Give Year or Dates:                                                             |                                    |                                         |                              | s: GU/                                | ARD                  | 1 ☐ Yes 2 💢 No                                | Specify:                                  |                                      |                       | Specify:                   | WHITE                            |                              |
| be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at                                                                                                                                   |                                |                                                                                                                                     | 15. Deceder                        | nt's Educat                             | ion , , ,                    | 40,                                   | 16a. Dec             | cedent's Usual Occu                           | pation                                    |                                      | 16b. I                | Vind of Busines            |                                  |                              |
| thin 7<br>e.<br>an "n<br>Medi                                                                                                                                                                                                                                                                            | Completed                      | Elementary/Seco                                                                                                                     | cify only highe<br>ondary (0-12)   | est grade c                             | College (1-4                 | or 5+)                                | 1                    | ve kind of work done<br>. DO NOT use retire   |                                           | King                                 |                       |                            |                                  |                              |
| ed wil<br>ygien<br>er th                                                                                                                                                                                                                                                                                 | Con                            |                                                                                                                                     |                                    |                                         | 1                            |                                       |                      | PROPRIETO                                     | ·                                         |                                      | 1                     | TAVER                      | <u>V</u>                         |                              |
| be fill<br>ntal H<br>ed oth                                                                                                                                                                                                                                                                              | Be                             | 17. Father's Name                                                                                                                   | ,                                  | , Last)                                 |                              |                                       | _                    |                                               | 18. Mother's Nan                          | , ,                                  | e, Maide              | ,                          |                                  |                              |
| 2 should be filed with<br>and Mental Hygiene.<br>is marked other than<br>aumatic event, the M                                                                                                                                                                                                            | ြ                              | HAF<br>19a. Informant's N                                                                                                           |                                    | ahin /Tuna                              | Print)                       | BAKE                                  |                      | illing Address (Street                        | PAUL<br>PAUL                              |                                      | har City              | GRUI                       |                                  |                              |
| d 2 sl<br>th an<br>t7 is r<br>traur                                                                                                                                                                                                                                                                      |                                | ELLEN M                                                                                                                             |                                    |                                         | ,                            | 2                                     | 1                    | 5 WEST ENI                                    |                                           |                                      |                       |                            | 10023                            |                              |
| ges 1 and 2 should be filed within 72 hours after death with the Marylar tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at                                                         |                                | 20a. Method of Dis                                                                                                                  |                                    | ,                                       |                              | 20b                                   | Place of Dis         | position (Name of                             | i                                         | Date                                 | _                     | ocation - City             |                                  | )                            |
| Pages 1<br>nent of H<br>nt: If iter                                                                                                                                                                                                                                                                      |                                | 1 X Burial 2<br>4 □ Donation                                                                                                        |                                    |                                         | oval from Sta                | ite OHE                               | B SHA                | rematory or other pla<br>DM<br>PARK           | 02/2                                      | 7/2008                               | REI                   | STERST                     | OWN. MI                          | )                            |
| + # <b>#</b> # -                                                                                                                                                                                                                                                                                         |                                | 21. Signature of F                                                                                                                  | ·                                  | • • • • • • • • • • • • • • • • • • • • |                              | (161)                                 | ONTAL                | 22. Name and Addre                            |                                           | OL LEVI                              |                       |                            |                                  |                              |
| permi<br>Depa<br>Impo<br>any ir<br>once.                                                                                                                                                                                                                                                                 |                                | (Au                                                                                                                                 | allant.                            |                                         |                              |                                       |                      | 8900 REIS                                     |                                           |                                      |                       |                            |                                  |                              |
|                                                                                                                                                                                                                                                                                                          |                                | 23a. Party Enter                                                                                                                    | the disease, o<br>art failure. Lis | r complica<br>t only one                | ions that cau                | sed the dea<br>h line.                | th. Do not e         | enter the mode of dyi                         | ng, such as cardiad                       | or respiratory                       | arrest,               |                            | Approxi<br>Interval              | mate<br>Between<br>Ind Death |
| Physician                                                                                                                                                                                                                                                                                                |                                | Immediale Cause<br>disease or condition                                                                                             | on                                 | a.                                      | Phe                          | umo                                   | nia                  |                                               |                                           |                                      |                       |                            | 100                              | 4                            |
| /Medical<br>Examiner                                                                                                                                                                                                                                                                                     |                                | resulting in death)                                                                                                                 |                                    |                                         | Due to (or                   | as a consec                           | quence of):          |                                               |                                           |                                      |                       |                            |                                  |                              |
| LAUIIIIICI                                                                                                                                                                                                                                                                                               | _                              | Sequentially list co                                                                                                                | onditions,                         | b                                       | Due to (or                   | as a consec                           | ruence of):          |                                               |                                           |                                      |                       |                            | -                                |                              |
| nsit 🔌 de                                                                                                                                                                                                                                                                                                | Examiner                       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Illijury that initiated events |                                    |                                         |                              |                                       |                      |                                               |                                           |                                      |                       |                            |                                  |                              |
| executed an and rial-transit                                                                                                                                                                                                                                                                             | Exal                           | resulting in death)                                                                                                                 | 15                                 | C                                       | Due to (or                   | as a consec                           | quence of):          |                                               |                                           |                                      |                       |                            |                                  |                              |
| icate be e<br>physician<br>s the buria                                                                                                                                                                                                                                                                   |                                |                                                                                                                                     |                                    | d                                       |                              |                                       |                      |                                               |                                           |                                      |                       |                            |                                  |                              |
| eath certificate be<br>attending physicis<br>for use as the bu                                                                                                                                                                                                                                           | Completed by Physician/Medical |                                                                                                                                     |                                    |                                         | _                            |                                       |                      |                                               |                                           |                                      |                       |                            |                                  |                              |
| tth ce<br>tendir<br>rr use                                                                                                                                                                                                                                                                               | an/N                           | IF FEMALE:<br>23b. Was deceder<br>in the past 12                                                                                    |                                    | 23c                                     | If yes, outco                |                                       |                      | 3 □Ectopic pregnanc                           | ;y                                        |                                      | 3)                    | 23d. Date of o             | lelivery<br>Day                  | Year                         |
| e dea<br>the at<br>ned fo                                                                                                                                                                                                                                                                                | sici                           | 1 ☐ Yes 2<br>9 ☐ Unknowr                                                                                                            | □ No                               |                                         | 4□Pregnan<br>9□Unknow        |                                       | death !              | 5 ☐ Other (specify) _                         | •                                         |                                      |                       | MOHILI                     | Day                              | rear                         |
| hat th<br>d by                                                                                                                                                                                                                                                                                           | Ph                             |                                                                                                                                     |                                    | ions contri                             | outing to deat               | h but not res                         | sulting in the       | underlying cause gi                           | ven in Part I.                            | 23e, Did                             | tobacco               | use contribute             | to the cause                     | of death?                    |
| signe<br>d be o                                                                                                                                                                                                                                                                                          | l by                           |                                                                                                                                     | ngesi                              |                                         | -                            |                                       | -                    |                                               |                                           | 13                                   | ]Yes                  | _                          | Probably 4                       |                              |
| v requ                                                                                                                                                                                                                                                                                                   | etec                           |                                                                                                                                     | -3                                 |                                         |                              |                                       |                      |                                               |                                           | 24a. Wa                              | e an                  | 24h Wara                   | autopsy findi                    | nge available                |
| he lav<br>e has<br>ige 2                                                                                                                                                                                                                                                                                 | mp                             |                                                                                                                                     |                                    | • • •                                   |                              |                                       |                      |                                               |                                           | aut<br>per                           | opsy<br>formed?       | prior t<br>death           | o completion                     | of cause of                  |
| an: T<br>tificate<br>or, pa                                                                                                                                                                                                                                                                              |                                | 25. Was case refe                                                                                                                   | erred to medica                    | al l                                    |                              |                                       |                      |                                               | 26. Place of Dea                          | 1 Yes                                |                       | [6] 1□Y                    | es 2 No                          |                              |
| ysicia<br>is ceri                                                                                                                                                                                                                                                                                        | To Be                          | examiner?<br>1 ☐ Yes 2 ☑                                                                                                            | _                                  |                                         | pital: 1 🗖 Inp               | atient 2                              | ]ER/Outpat           | ient 3 DOA Ot                                 | hor:                                      | lome 5 ☐ Re                          |                       | 6 □Other (Si               | pecify)                          | -                            |
| ig Ph<br>ter th<br>neral                                                                                                                                                                                                                                                                                 |                                | 27. Manner of Dea<br>1 ☑ Natural                                                                                                    | ath<br>5 ☐ Pendi                   |                                         | 28a. Date of (Month.         | Injury<br>Day Year)                   | 28b. Time<br>Injur   |                                               | iry at                                    | 28d. Describe                        | how inj               | ury occurred               |                                  |                              |
| endir<br>sath.<br>or: Al                                                                                                                                                                                                                                                                                 | atic                           | 2 Accident                                                                                                                          | invest                             | igation                                 |                              |                                       |                      | M 1                                           | ]Yes 2□No                                 |                                      |                       |                            |                                  |                              |
| or Att<br>ter de<br>lirect                                                                                                                                                                                                                                                                               | Certification:                 | 3 ☐ Suicide<br>4 ☐ Homicide                                                                                                         | 6 ☐ Could<br>deterr                |                                         | 28e. Place of<br>building    | injury - At h<br>, etc. <i>(Spe</i> c | iome, farm,<br>ify)  | street, factory, office                       |                                           | 28f. Location<br>City or T           | (Street a<br>own, Sta | and Number or<br>te)       | Rural Route I                    | Vumber,                      |
| pital o                                                                                                                                                                                                                                                                                                  |                                | 200 Cartifier                                                                                                                       | 1 Contifui                         | na Physic                               | ion. To the h                | ant of my kn                          | oulodgo do           | ath accurred at the t                         | ime, data and place                       | and due to th                        | 0.00100/              | (a) and manner             | on stated                        |                              |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu | Medical                        | 29a. Certifier<br>(Check only<br>one)                                                                                               | 2 Medica                           | I Examine                               | r: On the basi<br>and manner | s of examin                           | ation and/or         | ath occurred at the t<br>investigation, in my | opinion, death occi                       | urred at the time                    | e, date a             | nd place, and o            | ue to the cau                    | se(s)                        |
| Fo the<br>within<br>Fo the                                                                                                                                                                                                                                                                               | Me                             | 29b. Signature and                                                                                                                  | d title of certifie                | °K                                      |                              |                                       |                      | 29c. Licen                                    | se number                                 |                                      | and a                 | ate signed (Mo             |                                  | *                            |
| - > - 0                                                                                                                                                                                                                                                                                                  |                                |                                                                                                                                     |                                    | 1                                       |                              |                                       |                      | D63                                           | ø54                                       |                                      | FEB                   | PUARY 2                    | 5, 200                           | 8                            |
| 20                                                                                                                                                                                                                                                                                                       |                                | 30. Name and add                                                                                                                    | dress of persor                    | who com                                 | oleted cause                 | of death (Ite                         | m 23a) (Typ          | e, Print)                                     |                                           |                                      |                       | •                          |                                  |                              |
| 7                                                                                                                                                                                                                                                                                                        |                                | Majid C                                                                                                                             | ina, m                             | D., 9                                   | 000 Fran                     | Klin So                               | brane O              | rive, Bultino                                 | ne, Maryla                                | nd 2123                              | 37                    |                            |                                  |                              |
| Sta                                                                                                                                                                                                                                                                                                      |                                | 31. Date filed (Mor                                                                                                                 | nth, Day, Year                     | 8                                       | 32. Reg                      | istrar s Sign                         | Able Ag              |                                               |                                           |                                      |                       |                            |                                  |                              |
| Registr                                                                                                                                                                                                                                                                                                  | ar                             | FED                                                                                                                                 | H C LUO                            | and the same                            |                              |                                       |                      |                                               |                                           |                                      |                       |                            |                                  |                              |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician LERBROCK 0 + 2008 +ILDA M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** mp BALTIMORECIT JOHNS HOPKIND BANCEW ARECENIE If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 82 Yrs. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours 220-14-6282 1 M 2 1 F Sept8,1925 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County M☐Yes 2☐No Baltimore City Md. Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21224 155 South Grundy Street 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 ☐ No altimore, Maryland 21215-0036 Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Book Binder Bindery 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Werner John A. Ellerbrock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 155 South Grundy St. Baltimore, Md. 21224 Dolores Waters (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2-27-2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facilityaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cmen ha /Medical Due to (or as a consequence of) Examiner discus WKINDMS Sequentially list conditions, Due to for as a consequence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed attending physician and for use as the burial-transit P P P P Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ld be detached for 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page, perform 2/No certificate or Attending Physician: 25. Was case referred to medical director. 26. Place of Death Check onl one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after death

To the Funeral Director:
completely filled in by the i 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar 31. Date filed (Month,

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Bayria Cilde Balkmore MD LILLY

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lay

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last). 2. Date of Death 1650 **Physician** GEORGE ROWE /Medical 4c. County of Death 4h City Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Anne Arundel 1718 Leisure Lane Glen Burnie If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, May 2, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days **™** M 2□ F Yrs. 215-12-2090 90 1917 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b, County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21060 1718 Leisure Lane Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify þ White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Floor Tile Setting Co. Press Operator 8 permit. Pages 1 and 2 should be filed be partment of Health and Mental Hygid Important: If item 27 is marked other any injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alvin Crowe Rella Lancaster ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1718 Leisure Lane, Glen Burnie, Maryland 21060 Martha J. Carter (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Marriottsville, Md. Crestlawn Mem Gdns. 2/27/08 4 ☐ Donation 5 ☐ Other (Specify) Ecker 21. Signature of Fundal Service Licensee Kevin E 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown been signed by t should be detach 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 28h Time of Certification: 27, Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, ō

hours after death.

Ineral Director: After this
ly filled in by the funeral di within 24 hours a To the Funeral I the Hospital

Medical

State

Registrar

29a. Certifier

31. Date filed (Month, Day, Year,

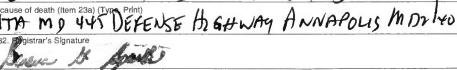
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🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fth 987/3-26-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** C/250 AM 23 FRANK CUSTODERO 02 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD UPPER CHESALEAKE MEDICAL CONNER BER AIR 200 Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min. 1**X**M 2□F 80 16-3762 OS-01-1927 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No **Funeral Director** Middle River Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21220 U.S.A. ce - American Indian, 6504\_Blackhead\_Road 14. Race -12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Yes 2 No 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: Be Completed by 3 X Widowed 4 ☐ Divorced WIII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Defense Contractor 12 Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be f Benjamino Custodero 2 Agnes Sacco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other traus 3/33/08 6502 Blackhead Road Middle River, Maryland 21220 Mrs. Tina Eurice - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 02/27, 2008 Parkville, Maryland 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. Meron Baltimore, Maryland 21214 Male 23a. Part1. Enter the prease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart in lure. List only one pruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Let under the Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Physician/Medical Examiner sician and burial-transit onemania Due to (or as a consequence of) attending physician for use as the buria roten IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown has been signed by ye 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page certificate 2 N6 After this certification fureral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes ို 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours at er death To the Funeral Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by lospital or A 4 Homicide 1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier oden 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) upper Ide Homra 31. Date filed (Month, Day, Year) FEB 2 8 Registrar's Sign State 2008 Com Registrar

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r ero, Frank

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #21, perFD, ©876, 2/28/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 26, 2008 **Physician** 3:35A Calhoun Mary Μ. /Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye Sept 25, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) <sup>Year)</sup> 1924 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2X F Maryland 217-12-8436 83 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at Director Towson 1 ☐Yes 2 TXNo Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 21286 205 E. Joppa Rd. #705 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No à 3 Widowed 4 Divorced White 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical and 2 should be filed within ealth and Mental Hygiene.
n 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marv M. Landers, Sr. Luby Joseph Τ. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 E. Joppa Rd. #705 Towson, Md. 21286 if Health a item 27 ls Ms. Mary Jo Siebert/ Daughter permit. Pages 1 a Department of Hea Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Md. Dulaney Valley Mem. 2-29-08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licenses Barbara Purdie (per DVR) Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** STROKE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the ! as 1 attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ No 3 Probably 4 Unknown 1 ☐ Yes CHRONIC ATRIAL FIBRILLATION Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an ISCHEMIC CARDIOMYOPATHY page 2 has autopsy certificate 2 No 2 XNo or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ıal or Αλ.
cours after death.
••al Director: After h.
•• by the funeral director. P 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 26/08 D37254 -ZI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

TOWSON.

MARYLAND

OSLER DRIVE,

7601 05L Registrar's Signature

Sieves

BOON POH LIM M. D

2008

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Reva Chasin

Stella Maris Hospice

5. Social Security Number

4a. Facility Name (If not institution, give street and number)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

7. Age (In yrs. last birthday)

Certificate of Death

Months

4b. City. Town, or Location of Death

Timonium If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

| Physician |  |
|-----------|--|
| /Medical  |  |
| Examiner  |  |

**Funeral** Director

Maryland 21215-0036 the Medical Saltimore,

FEBRUARY

The law requires that the death certificate be executed P.0. Division or Vital Records, CHASIN death.

1 □ M 2 🛛 F 94 324-03-0983 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code with 5833 Park Heights Ave. Unit 308 21215 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. em 27 is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify. 9 3₺Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Piano Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ike L. Glickson Annette Lipner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. David G. Chasin P.O. Box 164 Lutherville, Maryland permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2XX cremation 3 ☐ Removal from State Evans Funeral Chapel Feb.28,2008 | Forest Hill,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P. A 2325 York Road Timonium, Maryland 21093 23a. Party. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Cauce (Disease or injul that initiated events resulting in death) Last the burial-trar and Due to (or as a consequence of) attending physician Physician/Medical for use as IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an autopsy performe page 2 certificate or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this the funeral 28b. Time of 28c. Injury at Work? 28a. Date of Injury 27 Manner of Death (Month, Day Year) Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral I 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

2. Date of Death 3. Time of Death Month 10:40 P.M February 26, 2008 4c. County of Death Baltimore County 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Feb. 12, 1914 Chicago, Ill. 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian Black, White, etc. White 16b. Kind of Business/Industry Piano Teaching 21094-0164 20c. Location - City or Town, State 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) TIMONIUM, MD 21093

State Registrar

0

29b. Signature and ttle of certifier

31. Date filed (Month, Day, Year)

DR. TARIQ MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

32. Registrar's Signature

29c. License number

State Registrar

DHMH 17 Rev 1/2001

BRIAN C. WALLACE, M.D. 9005 KILBRIDE RD., NOTTINGHAM, MD 21236 31. Date filed (Month, Day, Year) 2008

29b. Signature and fittle of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D31136

29d. Date signed (Month, Day, Year)

FEBRUARY 23, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G877 3/03/08 IH
Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 26, 2008 Rosalie Charlotte Cegielski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Baltimore Towson Hours Min. Mar 12, 1943 Mary Land 6. Sex Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs 212-09-8427 1 □ M 2√□ F Months 64 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10h. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Md. Timonium Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or Items 23a or Examiner must be r 2520 Pot Spring Road U.S.A. 14. Race - American Indian, 21093 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation other traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 Is marked of Adam J. Cegielski, Sr. Stella Kaminiecki 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanore Anuszewski(sister) 610 48th St. Baltimore, Md. 2<del>1222</del> 21224 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-29-2008 Baltimore, Maryland Holy Rosary Cem. 22. Name and Address of Facilite aczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licenses Robert! 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) prosepsis Physician /Medical Due to (or as a conequence of): Examiner MKINSON Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy performed? Yes 2 (1) Yo page 1∐ Yes or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nisput 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely 29b. Signature and title of certifier ~m

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

6101

N. Charles St JOHSON MO ZIZOY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

J. CHARUES

HARIN

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Decedent's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         | - Lineare of D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Journ                        | 2. Date of Dea   | ith                 | JUÖ-                             | 3. Time o                             | f Death           |
|             | Physicia<br>/Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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|             | Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2.20           | 4a. Facility Name (If not institution, give street and number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                         | 4b. City, Town, or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                              |                  |                     | ty of Death                      | • 1                                   |                   |
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Date of Birtl |                     | Freder                           |                                       | or Foreign        |
|             | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                | 5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last</i> 1 № 1 × 2 F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         | Months Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Hours Min.                   | Aug 31           | /, Year)            | Virg                             | ace (State<br>inia                    | or Foreign        |
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|             | Ba-f s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Directo        | Maryland Frederick                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Monro                                   | OVÍA<br>10f. Zip Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                              | — Т              | 10a. Citizen o      | f What Coun                      |                                       |                   |
|             | with the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Ö              | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         | 21770                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                              |                  | US                  |                                  | ,                                     |                   |
|             | leath<br>ns 23<br>must                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Funeral        | 3513 Runkles Drive  11. Marital Status  12. Was Decedent Ever in U.S.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 13. W                                   | /as Decedent of His<br>Yes, specify Cubai                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              | ecify Yes or No- |                     | ace - Americ                     |                                       |                   |
| ٥           | be filed within 72 hours after death with the Maryland<br>ital Hyglene.<br>dother than "natural", or items 23a or 28a-f show<br>event, th. Medical Examiner must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 1 Neve | 2                                       | Yes, specify Cubai                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | n, mexican, Puerro  Specify: | Hican, etc.)     | - 1                 | ack, White, i                    |                                       |                   |
| 2-003p      | hours<br>ural",<br>al Exa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                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Kind of        | -                                |                                       |                   |
| ς<br>L      | in 72<br>''nat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| 717         | d withing in the state of the s | Completed      | Elementary/Secondary (0-12) College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Lette                                   | er Carrie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |                  | U.S. I              |                                  | Serv                                  | ice               |
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Mother's Name            |                  |                     | ame)                             |                                       |                   |
| yland       | ages 1 and 2 should be filed vent of Health and Mental Hygiest: If item 27 is marked other ty or other traumatic event, the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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|             | of Health<br>item 27                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | 20b. 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| altimore,   | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | 21. Signature of Funeral Service Licensee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 22                                      | Name and Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | s of Facility                | ·                |                     |                                  |                                       |                   |
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Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Do not ente                             | er the mode of dying                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | g, such as cardiac           | or respiratory a | rrest,              |                                  | Approxima<br>Interval Be<br>Onset and | etween<br>I Death |
|             | Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | enera                                   | Me C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | BOUSE                        |                  |                     |                                  | 5 4                                   | ceus              |
|             | /Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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Due to or as a consequent any, leading to introduce to the conditions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | nce of:                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                              |                  |                     | - 1                              |                                       |                   |
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Enter Underlying Cause (Disease or injury that initiated events                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                              |                  |                     |                                  |                                       |                   |
| ŠČ,         | cate be executed<br>physician and<br>the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| 9 X C       | leath certific<br>attending p<br>I for use as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | /Me            | IF FEMALE: 23c. If yes, outcome pf pregnant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                         | lun .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                              |                  | 23d.                | Date of deliv                    | ery                                   |                   |
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Box       | death<br>e atter<br>d for u                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Physician/Me   | in the past 12 months?  4 Pregnant at time of dea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         | ]Ectopic pregnancy<br>] Other <i>(specify)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <u> </u>                     |                  |                     | Month                            | Day                                   | Year              |
| <u>Р</u>    | at the<br>by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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                                                                                                                                                                                                                     | an in Bankl                  | Ogo Did i        | tobacco use co      | antributa to t                   | bo cause o                            | f death?          |
|             | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | by             | Part II. Other significant conditions contributing to death but not resulti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ing in the ur                           | iderlying cause give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | en in Pan I.                 |                  | Yes 2 No            |                                  | pably 4                               |                   |
| Records,    | requi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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                                                                                                                                                                                                                     | <del></del>                  | 24a. Was         |                     | b. Were auto                     | onsy finding                          | s available       |
| Re          | he law<br>s has l<br>ige 2 s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | dmo            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | - 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| Vital       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 25. Was case referred to medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 26. Place of Dea             |                  |                     | I 🗆 res                          | 20110                                 |                   |
| 5           | lysici<br>lis cer<br>direct                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | To Be          | examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   El                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | R/Outpatien                             | t 3□ DOA Oth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | er:<br>4 □ Nursing H         | ome 5 Resi       | idence 6 🗆          | Other (Speci                     | fy)                                   |                   |
| Division or | Attending Ph<br>or death.<br>ector: After th<br>by the funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                | 1 Natural 5 □ Pending (Month, Day Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 28b. Time of<br>Injury                  | Worl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                              | 28d. Describe    | how injury occ      | curred                           |                                       |                   |
| Sio         | ttendi<br>death.<br>:tor: A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | cati           | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury At hom                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ne. farm. str                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Yes 2 □ No                   | 28f. Location (  | Street and Nu       | mber or Rur                      | al Route No                           | umber,            |
|             | after d<br>Direc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Certification: | 4 Homicide determined building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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                                                                                                                                                                                                                     |                              | City or To       | wn, State)          |                                  |                                       |                   |
| _           | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, the funeral director, completely filled in by the funeral director,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                | 29a. Certifier  (Check only (C | ledge, deatl                            | n occurred at the tir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | me, date and place           | , and due to the | cause(s) and        | manner as                        | stated.<br>to the cause               | e(s)              |
|             | the H<br>nin 24<br>the Fi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Medical        | one) and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         | 29c. Licens                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                              |                  | 29d. Date sig       |                                  |                                       |                   |
| <b>\</b>    | Vitl<br>To<br>COU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 2              | 29b. Signature and title of centifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | hn                                      | Too. Licens                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 7667                         | )                | Fe                  |                                  | 28                                    | 2004              |
|             | 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | 30. Name and address of person/who completed cause of death (Item 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 23a) (Type.                             | Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2000                         |                  | 1 0                 |                                  |                                       |                   |
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| Ì           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ate            | 31. Date filed (Month, Day, Year)  September 32. Registrar's Signature 32. Registrar's Signature 33. Registrar's Signature | ire                                     | Land .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                              |                  |                     |                                  |                                       |                   |
| 100         | Reaist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 16.1           | TED G O / HID MEDICAL A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | CON ASS                                 | CONTRACTOR OF THE PARTY OF THE |                              |                  |                     |                                  |                                       |                   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ | | | | | For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Deleo 7:02 AM **Physician** 2008 February 20 4a. Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore City N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 17, 1 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1**X**M 2□F Yrs. 1946 213-46-0100 61 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 ie marked other then "naturel", or Iteme 23a or 28a-f ehow ury or other treumatic event, the Medical Examinar must be notified as 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 Yes 2X No Completed by Funeral Director Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21085 USA 621 Joppa Farm Road 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Colfege (1-4or 5+) Local Hauling Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Weber John De Leo ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24 Postman Lane Palm Coast, FL 32164 Bertha De Leo / mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If eny Injury or page. Metro Crematory, Inc. 02/26/08 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Diffuse Large B Cell Lymphoma 5 months **Physician** /Medical Due to (or as a consequence of): Examiner Ecquentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached t 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by been signe should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No 1 Yes 2 No certificate 1 Yes the Hospital or Attending Physician: director, Be 25 Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No Inpatient ို 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Medical RES-000 February 20, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILTrindade, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287 32 Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 8 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Eli73beth (0110 P M PELONA 26,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westmins Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 215-24-0892 8. Date of Birth (Month, Day, Year)
12-23-1928 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 ₽ F Director MARÝLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at MD CECIL PORT DEPOSIT 1 ☐ Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 HARFORD VIEW DRIVE 21904 U.S.A. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY WESTERN ELECTRIC 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be WILLIAM CROMWELL EDITH (GOLDSBOROUGH) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21904 19a. Informant's Name/Relationship (Type. Print) TERANCE ANN COX/DAUGHTER 13 HARFORD VIEW DRIVE PORT DEPOSIT, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MORELAND MEMORIAL 2-29-08 BALTIMORE, MD 22. Name and Address of Facilit CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner 105 Majum di Sequentially list conditions, many, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical as 1 IF FEMALE: If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy performed? Yes 2 No death? 2□ No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Man of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation (Month, Day Year) Injury 1 ∏Yes 2 ∏No 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10059943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Angelmo

31. Date filed (Month, Day, Year)

FEB 2

10

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32 Registrar's Signature

and physician the ass attending properties of ed by the a has this certificate

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show notified at

23a or e Director

Funeral

death with the Maryland

filed within 72 hours after

pe

I Hygiene.

Baltimore, Maryland 21215-0036

within 24 hours after uses...

To the Funeral Director: After this

"natural", or Items 23a δ Completed Medical Elementary/Secondary (0-12) the ent of Health and Mental Hygien
tt: If Item 27 is marked other th
y or other traumatic event \*h-17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any lnjury or other traumatic evone. Charles Gerome Spann 19a. Informant's Name/Relationship (Type. Print) John F. Doster, Sr. 20a. Method of Disposition 1 X gurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Sign the If Funeral Service Linens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 25. Was case referred to medical examiner? Be 1 Yes 2No P 27. Manner of Death Certification: 1 Natural 2 Accident 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26394 30. Name and address of person who competed cause of death (Item 23a) (Type, Print) 6569 N. CHARLES ST HYII WECLEIN DUNGUD 5150, 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 28 Registrar **ORIGINAL** 

|                                                                                                                                                                                                    |                   | Pleas                                                                              | se Type or Prin                                   |                        |                        |                                                   |                 |                                           |                             | _                | ble.                   |                                       |             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------------------------------------------------------------------------------|---------------------------------------------------|------------------------|------------------------|---------------------------------------------------|-----------------|-------------------------------------------|-----------------------------|------------------|------------------------|---------------------------------------|-------------|
|                                                                                                                                                                                                    |                   | For<br>State<br>Registrar Amend 20b                                                |                                                   |                        |                        |                                                   |                 | ia wenan                                  | Reg. !                      | 90               | 08                     | 06                                    | 140         |
| Physicia                                                                                                                                                                                           | an                | Decedent's Name (First, Middle                                                     | e, Last)                                          |                        |                        |                                                   |                 | 2. Date of Month                          |                             | Day              | Year                   | 3. Time of                            |             |
| /Medic                                                                                                                                                                                             | al                | Lillian M. Det                                                                     |                                                   |                        |                        | Alt Oil Town                                      | - I tion of i   | Feb.                                      | 13                          | 40 Count         | 2008                   | 3:40                                  | P M         |
| Examin                                                                                                                                                                                             | er                | 4a. Facility Name (If not institution Stella Maris H                               |                                                   |                        |                        | 4b. City, Town, o                                 |                 | Death                                     | 1                           | 4c. County       |                        |                                       |             |
| Funeral                                                                                                                                                                                            | 100               | 5. Social Security Number                                                          |                                                   | ge (In yrs. las        | st birthday)           | I Imoni<br>If Under 1 Year                        | If Under 24     | Hrs. 8. Date of                           | Birth                       |                  |                        | ace (State                            | or Foreign  |
| Director                                                                                                                                                                                           |                   | 171-20-7043                                                                        | 1□ M 2□XF                                         | 83                     | Yrs.                   | Months Days                                       | Hours           | Min. (Month, July                         | Day, Yea                    |                  | PA                     | ry)                                   |             |
| w w                                                                                                                                                                                                |                   | Usual Residence of Decedent  10a, State 10b, County                                |                                                   | 10c. City.             | Town or Lo             | cation                                            |                 |                                           | _                           |                  | 10                     | d. Inside C                           | ity Limits  |
| Maryla<br>f sho                                                                                                                                                                                    | lor               | 150                                                                                | ı/a                                               |                        | timor                  |                                                   |                 |                                           |                             |                  |                        |                                       | 2 No        |
| r 28a-<br>notif                                                                                                                                                                                    | Director          | 10e. Street and Number                                                             | ., α                                              | Dai                    | CIMOI                  | 10f. Zip Code                                     |                 |                                           | 10g. (                      | Citizen of       | What Count             | ry?                                   |             |
| ours after death with the Marylan ral", or Items 23a or 28a-f show Examiner must be notified at                                                                                                    | a D               | 4411 Grandview                                                                     | Ave.                                              |                        |                        | 21                                                | 211             |                                           |                             | USA              |                        |                                       |             |
| ems;                                                                                                                                                                                               | Funeral           | 11. Marital Status                                                                 | 12. Was Decedent<br>Armed Forces?                 | Ever in U.S.           | . 13. V                | Vas Decedent of I                                 | Hispanic Origin | n? (Specify Yes or<br>Puerto Rican, etc.) | No-                         | 14. Rad          | ce - America           |                                       |             |
| s afte                                                                                                                                                                                             | by Fu             | 1 ☐ Never Married 2 ☐ Marri<br>3 ☑ Widowed 4 ☐ Divorced                            | ied 1 ∏ Yes 2 ∏<br>If Yes, Give<br>Year or Dates: | No                     |                        | I∐Yes 21∏ No                                      | Specify:        |                                           |                             | Specif           |                        |                                       |             |
| 72 hours after death with the Maryland<br>"natural", or Items 23a or 28a-f show<br>odk al Examiner must be notified at                                                                             |                   | 15. Decedent                                                                       | t's Education                                     |                        | 16a. Deced             | lent's Usual Occu                                 | pation          |                                           | 16b.                        | Kind of B        | usiness/Ind            |                                       |             |
| hin 72<br>9.<br>an "ng<br>Medik                                                                                                                                                                    | plet              | (Specify only highes<br>Elementary/Secondary (0-12)                                | st grade completed) College (1-4or 5              | 5+)                    | (Give<br>life. L       | kind of work done<br>OO NOT use retire            | during most o   | of working                                | Ĭ.                          |                  |                        |                                       |             |
| er the                                                                                                                                                                                             | Completed         | 12                                                                                 | n/a                                               |                        | _Hom                   | emaker                                            |                 |                                           |                             | own H            |                        |                                       |             |
| be file                                                                                                                                                                                            | Be                | 17. Father's Name (First, Middle, a                                                | Last)                                             |                        |                        |                                                   |                 | s Name (First, Mid                        |                             |                  | me)                    |                                       |             |
| hould<br>d Mer<br>narke                                                                                                                                                                            | ဥ                 | Harvey Royer  19a. Informant's Name/Relationsh                                     | hip (Time Print)                                  |                        | 10h Mailin             | a Address (Street                                 |                 | ble Himme<br>or Rural Route Nu            |                             |                  | State Zin              | Cadal                                 |             |
| nd 2 s<br>Ith an<br>27 is r<br>traur                                                                                                                                                               |                   | Nicholas A. De                                                                     |                                                   |                        |                        |                                                   |                 |                                           | ,                           | •                |                        | ,                                     |             |
| S 1 ar                                                                                                                                                                                             | - 1               | 20a. Method of Disposition                                                         |                                                   | 20b. Pla               | ce of Dispos           | wood Lo<br>sition (Name of<br>natory or other pla | i               | 1 Rd. Ar                                  | 20c.                        | Location         | - City or To           | vn, State                             |             |
| Page<br>nent c<br>ant: If<br>ury or                                                                                                                                                                |                   | 1 🖾 Burial 2 □ Cremation<br>4 □ Conation 5 □ Other (Si                             |                                                   |                        |                        | edral Ce                                          | ·               | /18/2008<br><del>2/28/08</del>            | Ва                          | lto.             | , MD                   |                                       |             |
| permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical once. |                   | 2 Lign up 15 uneral Se vice                                                        | itons they                                        |                        |                        | . Name and Addre                                  |                 | I F T                                     |                             |                  |                        | _                                     |             |
|                                                                                                                                                                                                    |                   |                                                                                    | ary                                               | d 41 d 11-             | Destrict               | IO W. Pa                                          | ionia F         | Home of D                                 | nium                        | MD               | 121693                 | Inc.                                  |             |
|                                                                                                                                                                                                    |                   | 23a. Part1. Enter the disease, or shock, or heart failure.                         | only one cause di each li                         | a the death.<br>ine.   | Do not ente            | er the mode of dyl                                | ng, such as ca  | ardiac or respirato:                      | y arrest,                   |                  |                        | Approxima<br>Interval Be<br>Onset and | tween       |
| Physician<br>/Medical                                                                                                                                                                              |                   | disease or condition<br>resulting in death)                                        | a. COLON (                                        |                        |                        |                                                   |                 |                                           |                             |                  | -                      |                                       |             |
| Examiner                                                                                                                                                                                           |                   |                                                                                    | b .                                               | a conseque             | 71100 01).             |                                                   |                 |                                           |                             |                  |                        |                                       |             |
| ) D =                                                                                                                                                                                              | iner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as                                     | a conseque             | ence of):              |                                                   |                 |                                           |                             |                  |                        |                                       |             |
| eath certificate be executed attending physician and for use as the burial-transit                                                                                                                 | xaminer           | that initiated events<br>resulting in death) Last                                  | c<br>Due to (or as                                | 0.000000000            | anno ofi:              |                                                   |                 |                                           |                             |                  |                        |                                       |             |
| be ex<br>kcian a                                                                                                                                                                                   | MM                | <b>3</b> ,                                                                         | Due to (or as                                     | a conseque             | siice oi).             |                                                   |                 |                                           |                             |                  |                        |                                       |             |
| The law requires that the death certificate be to have been signed by the attending physicis bage 2 should be detached for use as the but                                                          | Physician/Medical |                                                                                    | d                                                 |                        |                        |                                                   |                 |                                           |                             |                  |                        |                                       |             |
| h cert                                                                                                                                                                                             | M/u               | IF FEMALE:<br>23b. Was decedent pregnant                                           | 23c. If yes, outcome                              |                        |                        | ]Ectopic pregnanc                                 | W.              |                                           |                             | 23d. Da          | ate of delive          |                                       |             |
| e deat                                                                                                                                                                                             | sicia             | in the past 12 months?<br>1 ☐ Yes 2 <b>X</b> No                                    | 4□Pregnant a                                      |                        |                        | Other (specify)                                   | ,y              |                                           | _                           | М                | onth                   | Day                                   | Year        |
| that the deed by the detached                                                                                                                                                                      | Phy               | 9 ☐ Unknown  Part II. Other significant condition                                  |                                                   | out not recult         | ting in the ur         | adorluina cauco ai                                | on in Part I    | 230 [                                     | id tobacc                   | CO USA CON       | tribute to th          | e cause of                            | death?      |
| signed I                                                                                                                                                                                           | å by              | , arm other signment condition                                                     | ma contributing to death b                        | out not result         | ang in the di          | idenying cause gi                                 | veri ii i aiti. |                                           |                             |                  | 3 ☐ Prob               |                                       | Unknown     |
| w requir<br>been si<br>should                                                                                                                                                                      | Completed         |                                                                                    |                                                   |                        |                        |                                                   |                 |                                           | Vas an                      | 1                | Were auto              | -                                     | : available |
| The lav                                                                                                                                                                                            | dwo               |                                                                                    | _                                                 |                        |                        |                                                   |                 | a                                         | utopsy<br>erform <u>e</u> d | l?               | prior to cor<br>death? | npletion of                           | cause of    |
|                                                                                                                                                                                                    | a                 | 25. Was case referred to medical                                                   | 1                                                 |                        |                        |                                                   | 26. Place o     | of Death (Check of                        | - 41                        | No               | 1 □ Yes                | 2□No                                  |             |
|                                                                                                                                                                                                    | To B              | examiner?<br>1 ☐ Yes 2 📉 No                                                        | Hospital: 1 ☐ Inpatio                             | ent 2 E                | R/Outpatien            | t 3□DOA Ot                                        |                 | sing Home 5 ☐ F                           |                             | e 6 <b>▼</b> IOt | her (Specif)           | HOSP                                  | ICE         |
| aling Physic<br>I.<br>After this<br>funeral di                                                                                                                                                     |                   | 27. Manner of Death 1 ▼ Natural 5 □ Pending                                        | 28a. Date of Inju                                 | ury<br>ay Year)        | 28b. Time of<br>Injury | Wo                                                |                 | 28d. Descr                                | ibe how ii                  | njury occu       | rred                   |                                       |             |
| ttend<br>Jeath.                                                                                                                                                                                    | icati             | 2 Accident investig 3 Suicide 6 Could n                                            | not be 280 Place of ini                           | iun, At hom            | no form etr            | M 1 = 1 = et, factory, office                     | ]Yes 2 ☐ No     |                                           | n (Ctron                    | t and Num        | ber or Rura            | l Pouto Nu                            | mbar        |
| lor A<br>after a<br>Dlrec                                                                                                                                                                          | Certification:    | 4 ☐ Homicide determi                                                               |                                                   | tc. (Specify)          | ie, iaiii, siii        | set, factory, office                              |                 |                                           | Town, S                     |                  | ber or mara            | Houte Nu                              | riber,      |
| spita<br>hours<br>ineral<br>y fillec                                                                                                                                                               |                   | 29a. Certifier 1  ☐ Certifyin                                                      | ng Physician: To the best                         | of my know             | ledge, death           | occurred at the t                                 | ime, date and   | place, and due to                         | the cause                   | e(s) and m       | nanner as st           | ated.                                 |             |
| in 24<br>in 24<br>ihe Fu                                                                                                                                                                           | Medical           | (Check only 2 Medical one)                                                         | Examiner: On the basis of and manner st           | of examination         | on and/or in           |                                                   |                 | h occurred at the ti                      | me, date                    | and place        | , and due to           | the cause                             | (s)         |
| To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director, After this completely filled in by the funeral di                                                         | Σ                 | 29b. Signature and title of certifier                                              |                                                   |                        |                        |                                                   | se number       | _                                         | 1                           |                  | ed (Month,             |                                       |             |
| 1                                                                                                                                                                                                  |                   |                                                                                    | _ ' ' /                                           |                        |                        |                                                   | 1372            | -5                                        | -                           | 211              | 410                    | Δ                                     |             |
| 14                                                                                                                                                                                                 |                   | 30. Name and address of person                                                     |                                                   |                        |                        |                                                   | DT3 60          |                                           |                             |                  |                        |                                       |             |
| Sta                                                                                                                                                                                                | •                 | DR. TARIQ MAHMO 31. Date filed (Month, Day, Year)                                  |                                                   | LANEY<br>rar's Signatu |                        | SY RD.                                            | LIMONIA         | JM, MD 21                                 | 093                         |                  |                        |                                       |             |

DHMH 17 Rev 1/2001

State

Registrar

FEB 2 8 2008

Director

Funeral

þ

1. Decedent's Name (First, Middle, Last)

tranklin

Maryland 10e. Street and Number

11 Marital Status

5. Social Security Number

574-10-1804

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

6804 Bessemer Ave.

1 ☐ Never Married 2 Married

3 Widowed 4 Divorced

6. Sex

Hospita

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates:

1 ★M 2 ☐ F

Baltimore

Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien. Important: If them 27 is marked other that any Injury or other two. Barber Shop 12 Years Barber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Kitzmiller Claude Duckworth ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary V. Duckworth (Wife) Baltimore, Maryland 6804 Bessemer Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 3/1/2008 Middle River, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 2.a. | art1. Enter the disease, or complications that caused the scath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bowel **Physician** Necrosis /Medical Due to (or as a consequence of): Examiner theresclerosis Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of): per tension Physician/Medical the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Y Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1/25 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive Baltimore, Md. 21237 000 Franklia Japredee 32. Registrar's Signature hee 31. Date filed (Month, Day, Year) State FEB 2 8 2008 Registrar **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

Days

21222

10f. Zip Code

1 ☐ Yes 2 No

Se (ale Year | If Under 24 Hrs

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Dundalk

Joseph Bruce Duckworth

Center

7. Age (In yrs. last birthday)

10c. City, Town or Location

2. Date of Death

Date of Birth (Month, Day, Year)

36

15,1935

Vear

timore

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 TYes 2 TNo

Maryland

White

08

4c. County of Death

10g. Citizen of What Country?

Specify:

United States

14. Race - American Indian

Black, White, etc.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** CHARD February 3008 22 /Medical c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dittingra Washington Malical Burnie JU US If Under 1 Year | If Under 24 Hrs. 9. Birthplace (St Country) 8. Date of Birth (Month, Day, Number 6. Sex **Funeral** Days 42-3298 1**⊠**M 2□F **Director** MAR Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND /+ A: 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛱 No Maryland 21215-0036 þ Specify: 3 N Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) JIANT UNKNOWN n and Mental Hygir 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. KEYIN BOONE TONI PACK SON DAUGHTER) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Burial 2 □ Cremation 3 □ Removal from State HALL UMC CEMETERY 02-2 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Ignature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sease or condition esulting in death) Physician /Medical Due to or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial-transit requires that the death certificate be executed Exami Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 No 3 Probably 4 Unknown icate has been siç 7, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 Z No Yes Division or Vital Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **(** N 1 hipatient 2 ER/Outpatient 3□ DOA မ within 24 hours after death.

To the Funeral Director: After this of ompletely filled in by the funeral director. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and

State Registrar

Devidson filed (Month, Day,

8

305 - HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

305 den

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 22, Lyle Quinten Englund February 2008 4:50 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph Medical Center Towson Baltimore County 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 471-18-1788 88 Nov.07,1919 Director Minnésota Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland | Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 E. Joppa Road Apt. 712 21286 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ White 3 Widowed 4 □ Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Salesman Mens Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin Englund Dagmar Hultgren ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 811 Mrs. Marion M. Shaw (Friend) 204 E. Joppa Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, Evans Funeral Chapel Feb. 27, 2008 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral&Cremation Ctr.,P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee P. L. En er ne diselse, or complication of that caused the death. Do not enter the mode of dyin as ck, or heart failur. List only one cause of the chine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ld /Medical (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ui as a curisequence of The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Z. the attending physician and resulting in death) Last Due to (or as consequence of): Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen: 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? res 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes 2 ER/Outpatient Certification: To 1 Inpatient 3□ DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury М 1 ☐ Yes 2 ☐ No 2 Accident hours after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) nd title of afti 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D53902 Monday, February 25,08 and address of person who completed cause of death (Item 23a) (Type, Print)

11ip Mac , M.D. 1447 York Road Suite 100 21093 Lutherville, Maryland Phillip Mac , M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Elegistrar's Signature

2008

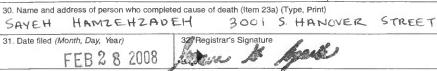
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | For<br>State<br>Registrar                                                                                                                            | State of M                                                                         | aryland        | -                                           | artment<br><i>rtificate</i>                       |                         |                                        | and Me                     | -                                         | giene<br>Rea. No            | 2000                      | 3 06                                 | 5   44                 |
|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------|---------------------------------------------|---------------------------------------------------|-------------------------|----------------------------------------|----------------------------|-------------------------------------------|-----------------------------|---------------------------|--------------------------------------|------------------------|
| See 4             | Physici<br>/Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | 1. Decedent's Name (First, Middle, La                                                                                                                | st)                                                                                | F              | FARME                                       | ER                                                |                         |                                        |                            | 2. Date of De<br>Month<br>EBRUAR          | Da                          |                           |                                      | e of Death             |
|                   | Examir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | 4a. Facility Name (If not institution, give street and number)  HARBUR HOSPITAL  4b. City, Town, or Location of Death  BAUTIMORE                     |                                                                                    |                |                                             |                                                   |                         |                                        |                            |                                           |                             | County of De              |                                      |                        |
|                   | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | 5. Social Security Number 6. S<br>213-30-4252  Usual Residence of Decedent                                                                           | Sex 7. Ag<br>1 ☐ M 2 🔀 F                                                           | 73 (In yrs. le | ast birthday)<br>Yrs.                       | If Under<br>Months                                | 1 Year<br>Days          | If Under<br>Hours                      | Min. 1                     | B. Date of Bir<br>1/8/19                  | th<br>1934 <sup>(ear)</sup> | 9. B<br>Ma                | irthplace (Sta<br>Country)<br>rylanc | ate or Foreign         |
|                   | e Maryland<br>3a-f show<br>tified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ctor           | 10a. State 10b. County Maryland Baltimor                                                                                                             | re .                                                                               |                | , Town or Lo                                | cation                                            |                         |                                        |                            |                                           |                             |                           | 1 🗆 '                                | e City Limits<br>Yes   |
|                   | ath with th<br>23a or 20<br>ust be no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ral Directo    | 10e. Street and Number 7358 Geise Ave.                                                                                                               |                                                                                    |                |                                             | 10f. Zip<br>212                                   | 219                     |                                        |                            |                                           | Unit                        | tizen of What (           | tes                                  |                        |
| 036               | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ ★Divorced                                                                         | 12. Was Decedent<br>Armed Forces?<br>1 ☐ Yes 2 ☑<br>If Yes, Give<br>Year or Dates: |                |                                             | Was Deced<br>If Yes, spec<br>1 ☐ Yes 2            |                         | ispanic Ori<br>in, Mexicar<br>Specify: | igin? (Spec<br>n, Puerto R | ify Yes or No<br>ican, etc.)              | -                           | 14. Race - An Black, Wh   | nite, etc.                           | n,                     |
| 21215-0036        | filed within 72 ho<br>Hygiene.<br>ther than "naturent, the Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Completed      | 15. Decedent's E<br>(Specify only highest gr<br>Elementary/Secondary (0-12)<br>12th                                                                  | ducation<br>ade completed)<br>College (1-4or                                       | 5+)            | (Give<br>life.                              | dent's Usua<br>kind of wor<br>DO NOT us<br>nistra | rk done d<br>se retired | durina mos                             | at of working              | 7                                         |                             | and of Busines            | -                                    |                        |
| Maryland 2        | 2 should be filed<br>and Mental Hygi<br>is marked other<br>aumatic event, ti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Be             | 17. Father's Name ( <i>First, Middle, Las.</i><br>Charles Farmer                                                                                     | )                                                                                  |                |                                             |                                                   |                         | Anna                                   | Korc                       |                                           |                             |                           |                                      |                        |
|                   | 1 and 2 sho<br>Health and<br>tem 27 is me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | 19a. Informant's Name/Relationship<br>Mrs. Anna Bush                                                                                                 | (Type. Print)<br>(Daughte:                                                         |                | 7358                                        | Geise                                             | e Ave                   |                                        | dgeme                      | re, Ma                                    | ryla                        | or Town, State<br>and 212 | 19                                   |                        |
| Baltimore,        | permit. Pages 1 a Department of Hei Important: If Item any injury or othe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 7 ☐ Other (Speci                                                                | Removal from State                                                                 | 0              | lace of Dispo<br>emetery, creating<br>Lop S | matorý or o<br>Servic                             | ther place<br>ce Co     | orp                                    | Da<br>2/25/                | 2008                                      | Tows                        | ocation - City o          | ryland                               |                        |
| Bal               | permit. Page<br>Department (<br>Important; If<br>any injury or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 21. Signature of Puneral Solice per                                                                                                                  | Lall                                                                               |                | 70                                          | 22 Wi                                             | ise 7                   | Ave.                                   | Dunda                      | lk. Ma                                    | rvla                        | dalk, I<br>and 212        | 22                                   | imata                  |
| 100               | Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | 23a. Part1. Enter the disease, or con<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | a. Due to (or as                                                                   | A A            | DENOC                                       |                                                   |                         |                                        | STA                        | 4.5                                       | irrest,                     |                           | Onset a                              | I Between<br>and Death |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                    | b                                                                                  | a consequ      | uence of):                                  |                                                   |                         |                                        |                            |                                           |                             |                           |                                      |                        |
| 68760,            | eath certificate be executed attending physician and for use as the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | edical Exa     | resulting in death) Last                                                                                                                             | Due to (or as                                                                      | a consequ      | uence of):                                  |                                                   |                         |                                        |                            |                                           |                             |                           |                                      |                        |
| P.O. Box 6        | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown                                                                | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant a<br>9 □ Unknown            | 2 Feta         | death 3                                     | ⊒Ectopic pr<br>⊒ Other <i>(</i> sp                |                         | /                                      |                            |                                           |                             | 23d. Date of o            | delivery<br>Day                      | Year                   |
|                   | quires that<br>n signed by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | þ              | Part II. Other significant conditions                                                                                                                | contributing to death I                                                            | out not resu   | ulting in the u                             | inderlying c                                      | ause giv                | en in Part I                           | I.                         |                                           |                             | use contribute            |                                      | e of death?            |
| or Vital Records, | The<br>ate h<br>page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Completed      |                                                                                                                                                      |                                                                                    |                |                                             |                                                   |                         |                                        | _                          | 24a. Was<br>auto<br>perf<br>1 Yes         |                             | prior t<br>death          | to completion?                       |                        |
|                   | ding Physician: The n. After this certificate hi funeral director, page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | To Be          | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☐ Natural 5 ☐ Pending                                             | Hospital: 1 Inpat 28a. Date of Inj (Month, D.                                      | ury            | ER/Outpatie                                 |                                                   | Oth                     | er: 4□Ni                               | ursing Hom                 | (Check only<br>ne 5 ☐ Res<br>8d. Describe | idence                      | 6 □Other (Survey occurred | pecify)                              |                        |
| Division          | Attener deatlector:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Certification: | 2 Accident investigatic 3 Suicide 6 Could not I 4 Homicide determined                                                                                | on 28e. Place of in                                                                |                | ome, farm, st                               | М                                                 | 10                      | Yes 2□                                 |                            | 8f. Location<br>City or To                |                             | nd Number or<br>te)       | Rural Route                          | Number,                |
|                   | To the Hospital or within 24 hours afte To the Funeral Discompletely filled in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Medical C      |                                                                                                                                                      | hysician: To the bes<br>iminer: On the basis<br>and manner s                       | of examina     |                                             |                                                   |                         |                                        |                            |                                           |                             |                           |                                      | use(s)                 |
|                   | To the within To the complete | Me             | 29b. Signature and title of certifier                                                                                                                | PHYSICIF                                                                           | +N             |                                             |                                                   |                         | e number                               | 1                          |                                           |                             | ate signed (Mo            |                                      |                        |

State Registrar

31. Date filed (Month, Day, Year)

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FEBRUARY 22, 2008

BALTIMORE, MD 21225

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) Month 10 **Physician** 21 2008 Mary Giambalvo /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Har fo + Kehab Bel Air Health enter Under 1 Year ce (State or Foreign 8. Date of Birth (Month, Day, 9. Birthplace (St Country) New York Social Security Number 6. Sex Age (In yrs. last birthday) Yrs. **Funeral** Months Hours 1□M **%**□F 07-06-1911 096-18-8159 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Director Bel Air Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21015 930 Whispering Ridge Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BAnk Bank Teller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madeline (Unknown) Paul Falbo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 930 Whispering Ridge Lane Bel Air, MD 21015 Lee Stauch (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 02-25-2008 | Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Li en e Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Ka na 20 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final demen Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗍 Yes Be Completed director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy certificate has death? 1 ☐ Yes performed? 2 1 No 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3□ DOA 2 ER/Outpatient 1 🗌 Yes 1 🔲 Inpatient Certification: To this 27. Mann Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? After (Month, Day Year) Injury Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide

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> State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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Medical

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32. Registrar's Signature

Contract of the

30. Name and address of person who completed cause of death (Item 23a) Type, Print

2008

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 4:35A M FLORETTA GREWDILLAE FEBRUARY 18, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6210 KINSEY TERRACE PRINCE GEORGES LANHAM 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) 1 □ M **XX**F Days Months Hours Director 578**-**56-4983 64 08-24-1943 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1√ Yes 2 No Director MD Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6210 Kinsey Terrace 20706 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ Specify: Black 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3yrs, Paralegal Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H f item 27 is marked oth Be Floyd McIntosh Carolyn Majors ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6210 Kinsey Terrace, Lanham, MD 20706 Tonia Briscoe/daughter Baltimore, permit. Pages 1
Department of He
Important: If iten
any Injury or oth 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2-22-2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, D. ORO 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Colon Carcinoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed Due to (or as a consequence of) burial-Box 68760, physician s the burial-Physician/Medical as attending use IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy for in the past 12 months? Month 5 ☐ Other (specify) P.0. the 9□Unknown 9 Unknown þ signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XIUnknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes **XX**No 2□ No 1 ☐ Yes 1∐ Yes rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home XX Residence 6 Other (Specify) **3**CXNo Fo the Hospitan within 24 hours after death.

To the Funeral Director: After this of the Funeral Director After this of the funeral difference of the function of the funeral difference of the funeral 2 1 Inpatient 2 ER/Outpatient 3 DOA Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examina tion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifig 29c. License numbe 29d. Date signed (Month, Day, Year) 101021501 02/19/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Dobriynski, MD 5226 Dawes Ave., Alexandria, VA 22311 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician February 21 4:15 2008 Mildred Bertha Gianzanti /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 4917 Catalpha Road Baltimore 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex Social Security Number **Funeral** Days Hours 02/23/P927<sup>ear)</sup> Months 80 1 ☐ M 2**X**☐ F New Jersey 189-20-6954 Director Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Menta Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 X Yes 2 ☐ No N/A Maryland Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21214 4917 Catalpha Road Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White δ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Industry Seamstress 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Ross Jacob Danowicz ဥ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4917 Catalpha Road Baltimore, Maryland 21214 <u>Mr. Anthony Gianzanti - Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. 02/26/2008 Parkville, Maryland 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Meson Baltimore, Marvland 21214 Markes 23a. Part1. Enter the disease, or complications trail aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** tiom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dut to for as a consequence Examine and C The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown Day 4☐Pregnant at time of death 5 Other (specify) be detached 9☐Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? /es 2 2 No has certificate 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient Certification: To After this funeral 27. Manner of Death

1 Natural

2 □ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide completely filled in by determined 4 ☐ Homicide To the Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Ellipsis\*\* Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

₹(I

2. Registrar's Signature

E95ter D-7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

-LIDAY

FEB28

31. Date filed (Month, Day, Year)

3509

DOO 211303

2/25/0

|                                                                                                                                                                                                                                                                                                                                  |                                | For State                                                                                                                                                                                                                         | State of Marylan                                                                                         |                                                | artment of I                                                                                                      |                                                        |                                                                                |                                                  |                                |                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------|----------------------------------------------------------|--|
|                                                                                                                                                                                                                                                                                                                                  |                                | Registrar  1. Decedent's Name (First, Middle, Last)                                                                                                                                                                               |                                                                                                          | 2. D                                           |                                                                                                                   |                                                        |                                                                                |                                                  | Reg. No.                       |                                                          |  |
| Physic<br>/Med                                                                                                                                                                                                                                                                                                                   |                                | BARRY                                                                                                                                                                                                                             | JON                                                                                                      | G(                                             | OODMAN                                                                                                            |                                                        | <del> </del>                                                                   |                                                  |                                | 3:20A M                                                  |  |
| Exami                                                                                                                                                                                                                                                                                                                            | ner                            | 4a. Facility Name (If not institution, give s<br>MARYLAND GENERAL                                                                                                                                                                 |                                                                                                          | 4b. City, Town, or Location of Death BALTIMORE |                                                                                                                   |                                                        |                                                                                | N/A                                              |                                |                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                              |                                | 5. Social Security Number 6. Sex 215-60-6353                                                                                                                                                                                      | 7. Age (In yrs. 44                                                                                       | last birthday)<br>Yrs.                         | If Under 1 Year<br>Months Days                                                                                    |                                                        | 8. Date of Birth (Month, Day, 10/08/                                           | <sup>Year)</sup><br>1963                         | 9. Birthpl                     | ace (State or Foreign<br>ry) MD                          |  |
| ryland<br>how                                                                                                                                                                                                                                                                                                                    |                                | Usual Residence of Decedent  10a. State 10b. County                                                                                                                                                                               |                                                                                                          | y, Town or Lo                                  |                                                                                                                   |                                                        |                                                                                |                                                  |                                | od. Inside City Limits                                   |  |
| the Ma<br>28a-f s<br>notified                                                                                                                                                                                                                                                                                                    | Director                       | MD N/A  10e. Street and Number                                                                                                                                                                                                    | BA                                                                                                       | LTIMORI                                        | 10f. Zip Code                                                                                                     |                                                        | 1                                                                              | 0g. Citizen of                                   | What Coun                      |                                                          |  |
| h with<br>3a or<br>st be                                                                                                                                                                                                                                                                                                         | i Di                           | 131 WEST LANVALE                                                                                                                                                                                                                  | STREET                                                                                                   |                                                | 21                                                                                                                | 217                                                    |                                                                                |                                                  | USA                            |                                                          |  |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral                     |                                                                                                                                                                                                                                   | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates:          |                                                | Was Decedent of<br>If Yes, specify Cul<br>1 ☐ Yes 2 No                                                            | Hispanic Origin? (S<br>ban, Mexican, Puerl<br>Specify: | pecify Yes or No-<br>to Rican, etc.)                                           |                                                  | ace - America<br>ack, White, o |                                                          |  |
| 215-0(<br>hin 72 hou<br>e.<br>In "natura<br>Medical E                                                                                                                                                                                                                                                                            | Completed                      | 15. Decedent's Edu<br>(Specify only highest grade                                                                                                                                                                                 | cation<br>e completed)<br>College (1-4or 5+)                                                             | (Give<br>life. L                               | edent's Usual Occupation e kind of work done during most of working DO NOT use retired) ICINSURANCE_ADJUSTER IRIR |                                                        |                                                                                | 16b. Kind of I                                   |                                |                                                          |  |
| 21.                                                                                                                                                                                                                                                                                                                              | No.                            |                                                                                                                                                                                                                                   | 4                                                                                                        | PUBL                                           |                                                                                                                   |                                                        |                                                                                |                                                  |                                | RANCE                                                    |  |
| rland uld be file Aental Hy rked oth                                                                                                                                                                                                                                                                                             | To Be (                        | 17. Father's Name (First, Middle, Last) WILLIAM                                                                                                                                                                                   | R                                                                                                        | GOODI                                          | MAN                                                                                                               | *                                                      | NSTEIN                                                                         |                                                  |                                |                                                          |  |
| Mary d 2 shou th and h 7 Is mai                                                                                                                                                                                                                                                                                                  |                                | 19a. Informant's Name/Relationship (Ty, WILLIAM GOODMAN                                                                                                                                                                           | , , , , , , , , , , , , , , , , , , ,                                                                    | 1                                              |                                                                                                                   | et and Number or Ri                                    |                                                                                | -                                                |                                | Code)<br>21208                                           |  |
| ages 1 annt of Healt<br>If item 2                                                                                                                                                                                                                                                                                                |                                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R                                                                                                                                                                         | 20b. I                                                                                                   | Place of Dispo<br>cemetery, crer               | sition (Name of<br>matory or other pl                                                                             | ace)                                                   | Date                                                                           | 20c. Location                                    | - City or To                   | wn, State                                                |  |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or any injury or other traumatic event, the Medical Examinonce.                                                                           | 1 S                            | 1   Burrial 2   Cremation 3   Removal from State 4   Donation 5   Other (Specify)   BALTIMORE HEBREW   02/27/2008   REISTERSTO   22. Name and Address of Facility   SOL LEVINSON & BROS   8900   REISTERSTOWN   ROAD - PIKESVILLE |                                                                                                          |                                                |                                                                                                                   |                                                        |                                                                                |                                                  |                                | , INC.                                                   |  |
|                                                                                                                                                                                                                                                                                                                                  |                                | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                         |                                                                                                          |                                                |                                                                                                                   |                                                        |                                                                                |                                                  |                                |                                                          |  |
| S8760, Medical Examiner physician and the burial-transit                                                                                                                                                                                                                                                                         |                                | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last       | Due to (or as a consec                                                                                   | quence of):                                    | librille<br>lise In                                                                                               | lanter.                                                | 20                                                                             |                                                  |                                | 1/2 hom<br>1 hom                                         |  |
| Box 6  Bath certif attending for use as                                                                                                                                                                                                                                                                                          | Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No                                                                                                                                                           | 3c. If yes, outcome pf pregn 1 □Live birth 2 □ Fet 4 □ Pregnant at time of to                            | aldeath 3[                                     | h 3⊟Ectopic pregnancy<br>5□ Other (specify)                                                                       |                                                        |                                                                                |                                                  | Date of delive                 | ery<br>Day Year                                          |  |
| Accords, P.O. It law requires that the de has been signed by the a ge 2 should be detached                                                                                                                                                                                                                                       | d by P                         | Part II. Other significant conditions con HIV (Osease                                                                                                                                                                             | ntributing to death but not res                                                                          | sulting in the u                               | nderlying cause g                                                                                                 | given in Part I.                                       | 23e. Did to                                                                    | 5 /                                              |                                | ne cause of death?<br>pably 4                            |  |
|                                                                                                                                                                                                                                                                                                                                  | Complete                       |                                                                                                                                                                                                                                   |                                                                                                          |                                                |                                                                                                                   |                                                        | 24a. Was a autop perfor                                                        | sy /                                             | prior to co death?             | psy findings available<br>mpletion of cause of<br>2 ☐ No |  |
| or Vital F Physician: Th r this certificate ral director, pag                                                                                                                                                                                                                                                                    | Be                             | 25. Was case referred to medical examiner?                                                                                                                                                                                        | Hospital: 1 ☐ Inpatient 2                                                                                | ER/Outpatier                                   | nt 3 DOA O                                                                                                        | thor                                                   | ath (Check only or                                                             |                                                  | Other (Cassi                   |                                                          |  |
| on or<br>ling Phy<br>After this<br>funeral di                                                                                                                                                                                                                                                                                    | ion: To                        | 27. Manner of Death 1                                                                                                                                                                                                             | 28a. Date of Injury<br>(Month, Day Year)                                                                 | 28b. Time o                                    | f 28c. Inj                                                                                                        | ury at<br>ork?                                         | T                                                                              | sidence 6 □Other (Specify) e how injury occurred |                                | <i>y)</i>                                                |  |
| Division or Vital i or Attending Physician: T after death. I Director: After this certificat d in by the funeral director, p                                                                                                                                                                                                     | Certification:                 | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined                                                                                                                                                           | M 1 ☐ Yes 2 ☐ No  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |                                                |                                                                                                                   |                                                        | 28f. Location (Street and Number or Rural Route Number<br>City or Town, State) |                                                  |                                | al Route Number,                                         |  |
| 29a. Certifier  29a. Certifier  29a. Certifier  29b. Signature and title of certifier  29c. License number  29d. Date states of the cause (s) and manner stated.  29d. Date states of the cause (s) and manner stated.                                                                                                           |                                |                                                                                                                                                                                                                                   |                                                                                                          |                                                |                                                                                                                   |                                                        |                                                                                |                                                  |                                |                                                          |  |
|                                                                                                                                                                                                                                                                                                                                  |                                |                                                                                                                                                                                                                                   |                                                                                                          |                                                |                                                                                                                   |                                                        |                                                                                | 29d. Date sig                                    |                                |                                                          |  |
| 00                                                                                                                                                                                                                                                                                                                               |                                | 30. Name and address of person who co                                                                                                                                                                                             | otoky MO                                                                                                 | m 23a) (Type                                   | Print)                                                                                                            | 13004                                                  |                                                                                | 2-                                               | 26-0                           | 8 HOZ1201                                                |  |
| J.0                                                                                                                                                                                                                                                                                                                              |                                | RONALD S. POTO                                                                                                                                                                                                                    | JSKY M.D.                                                                                                | 821                                            | N. EUT                                                                                                            | IN ST 80                                               | NE 202                                                                         | BALT                                             | Tmore                          | Horno                                                    |  |
| S                                                                                                                                                                                                                                                                                                                                |                                | 31. Date filed (Month, Day, Year)                                                                                                                                                                                                 | State 31. Date filed (Month, Day, Year) 32. Registrar's Signature                                        |                                                |                                                                                                                   |                                                        |                                                                                |                                                  |                                |                                                          |  |

DHMH 17 Rev 1/2001

|                            |                                                                                                                                                                                                                                                                                                                                                                                    |                     | For State                                                                                                                         | State of Maryland                                                                                 |                                         | rtment of H                                                    |                                          |                                       | 2000                                            | 0511.9                                                          |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------------------|------------------------------------------|---------------------------------------|-------------------------------------------------|-----------------------------------------------------------------|
|                            |                                                                                                                                                                                                                                                                                                                                                                                    | u                   | Registrar  1. Decedent's Name (First, Middle, Las                                                                                 | 0 0 01                                                                                            |                                         | uncate or t                                                    | Jeain                                    | 2. Date of Dea                        | Reg. No. UUU                                    | 3. Time of Death                                                |
| S. Office States           | Physici<br>/Medio                                                                                                                                                                                                                                                                                                                                                                  |                     | Mane                                                                                                                              | Goldbe                                                                                            | rg                                      |                                                                |                                          | Feb.                                  | 26th 200                                        | 8 3.45 pm                                                       |
|                            | Examir                                                                                                                                                                                                                                                                                                                                                                             | er                  | 4a. Facility Name (If not institution, give Future (are Cherry                                                                    | terstand                                                                                          | RD                                      | 0. 1                                                           | Location of Death                        | 1                                     | Bauti                                           | nore                                                            |
|                            | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                |                     | 5. Social Security Number 6. Se                                                                                                   |                                                                                                   |                                         | If Under 1 Year<br>Months Days                                 | If Under 24 Hrs.<br>Hours Min.           | 8. Date of Birt<br>Sept.              | 7, 1916 9. Bir                                  | thplace (State or Foreign ountry) PA                            |
|                            | ryland<br>how                                                                                                                                                                                                                                                                                                                                                                      |                     | 10a. State 10b. County                                                                                                            |                                                                                                   | , Town or Loc                           | ation                                                          |                                          |                                       |                                                 | 10d. Inside City Limits                                         |
|                            | the Ma<br>28s-f s                                                                                                                                                                                                                                                                                                                                                                  | ecto                | MD BALTIMO                                                                                                                        | ORE                                                                                               | REIS                                    | TERSTOWN                                                       |                                          |                                       | 10g. Citizen of What C                          | 1 ☐ Yes 2 🐧 No                                                  |
|                            | 3a or                                                                                                                                                                                                                                                                                                                                                                              | ai Dir              | 12020 REISTERSTO                                                                                                                  | OWN ROAD                                                                                          |                                         |                                                                | 1136                                     |                                       | USA                                             |                                                                 |
| 980                        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "naturel", or items 23a or 28a-f show importent: If Item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at ance. | by Funeral Director | 11. Marital Status  1  Never Married 2 Married  3  Wildowed 4 Divorced                                                            | 12. Was Decedent Ever in U.S<br>Armed Forces?<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates: |                                         | /as Decedent of Hi<br>Yes, specify Cuba                        |                                          | pecify Yes or No<br>o Rican, etc.)    | 14. Race - Am-<br>Black, Whi                    | erican Indian,                                                  |
| 21215-0036                 | thin 72 ho<br>e.<br>en "natur<br>Wedical I                                                                                                                                                                                                                                                                                                                                         | Completed           | 15. Decedent's Ed<br>(Specify only highest gra-<br>Elementary/Secondary (0-12)                                                    | ucation<br>de completed)<br>College (1-4or 5+)                                                    | (Give F<br>life. D                      | ent's Usual Occupa<br>aind of work done of<br>ONOT use retired | ation<br>during most of wor<br>)         | king                                  | 16b. Kind of Business                           | Industry                                                        |
|                            | filed wi<br>Hygien<br>other th                                                                                                                                                                                                                                                                                                                                                     |                     | 8 17. Father's Name (First, Middle, Last)                                                                                         |                                                                                                   | 5                                       | SALES                                                          | 18 Mother's Nan                          | ne (First Middle                      | CHINA AN<br>Maiden Sumame)                      | D CRYSTAL                                                       |
| Maryland                   | should be and Mental I marked o                                                                                                                                                                                                                                                                                                                                                    | To Be               | ROCK  19a. Informant's Name/Relationship (7)                                                                                      | MARSALN State                                                                                     | 10b Mailin                              | Address (Street                                                | STE                                      | PHANIE                                | UNOBTA                                          |                                                                 |
| Ma                         | and 2 signal and 2 signal and 27 ls r                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                   | ANDDAUGHTER                                                                                       |                                         | CHARING                                                        |                                          |                                       |                                                 | 21117                                                           |
| Baltimore,                 | Pages 1 and of He out. If Item                                                                                                                                                                                                                                                                                                                                                     |                     | 20a. Method of Disposition  1 Durial 2 Cremation 3 D                                                                              | Removal from State TW1                                                                            | ace of Dispos                           | ation (Name of<br>atory or other place                         | e)                                       | Date                                  | 20c. Location - City or                         |                                                                 |
| Ē                          | artmen<br>ortent:<br>injury                                                                                                                                                                                                                                                                                                                                                        |                     | 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen                                                            | ) MEN                                                                                             | ORIAL                                   | PARK                                                           | 02/2                                     |                                       | DELMONT, P<br>ISON & BROS                       |                                                                 |
| Ba                         | permit<br>Departr<br>Importe<br>any inji                                                                                                                                                                                                                                                                                                                                           |                     | Mest ber                                                                                                                          |                                                                                                   |                                         |                                                                |                                          |                                       | PIKESVILLE                                      |                                                                 |
| 6 h                        | Physician                                                                                                                                                                                                                                                                                                                                                                          |                     | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition | plications that caused the death<br>one cause on each line.                                       | <b>a</b> .                              | r the mode of dyin                                             |                                          |                                       | rest,                                           | Approximate<br>Interval Between<br>Onset and Death              |
| 1                          | /Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                               |                     | resulting in death)                                                                                                               | Due to (or as a consequ                                                                           |                                         |                                                                |                                          |                                       |                                                 |                                                                 |
| 泰                          | The state of                                                                                                                                                                                                                                                                                                                                                                       | ner                 | Sequentially list conditions, if they leading to immediate cause. Forer Underlying                                                | b. Due to (or as a consequ                                                                        | ence of):                               |                                                                |                                          |                                       |                                                 | ,                                                               |
|                            | cate be executed by sicien and the burial-transit                                                                                                                                                                                                                                                                                                                                  | icai Examiner       | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events<br>resulting in death) Last                          | c. Due to (or as a consequ                                                                        | ence of):                               |                                                                |                                          |                                       |                                                 |                                                                 |
| 8760,                      | le be ex<br>/sicien<br>e buria                                                                                                                                                                                                                                                                                                                                                     | caiE                |                                                                                                                                   | d.                                                                                                | 31133 317.                              |                                                                |                                          |                                       |                                                 |                                                                 |
| 9                          | ertificat<br>ling phy<br>e as th                                                                                                                                                                                                                                                                                                                                                   | Medi                | IF FEMALE:                                                                                                                        |                                                                                                   |                                         |                                                                |                                          |                                       |                                                 |                                                                 |
| P.O. Box                   | The law requires that the death certificate be executed to has been signed by the attending physicien and age 2 should be detached for use as the burial-transit                                                                                                                                                                                                                   | Physician/Med       | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Mo 9 ☐ Unknown                                                        | 23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown   | death 3                                 | Ectopic pregnancy<br>Other (specify)                           |                                          |                                       | 23d. Date of de<br>Month                        | Day Year                                                        |
| rds, P                     | w requires that<br>been signed b<br>should be deti                                                                                                                                                                                                                                                                                                                                 | þ                   | Part II. Other significant conditions of                                                                                          | ontributing to death but not resu                                                                 | lting in the un                         | derlying cause give                                            | en in Part I.                            |                                       | obacco use contribute t<br>res 2 🗆 No 3 🗆 P     | o the cause of death?                                           |
| Division of Vital Records, | The law racate has be page 2 sh                                                                                                                                                                                                                                                                                                                                                    | Completed           |                                                                                                                                   |                                                                                                   |                                         |                                                                |                                          |                                       | rmed? prior to death?                           | utopsy findings available completion of cause of s 2 \square No |
| Z<br>Z                     | sician:<br>certificirector                                                                                                                                                                                                                                                                                                                                                         | Be                  | 25. Was case referred to medical examiner?  1  Yes 2  0                                                                           | Hospital:                                                                                         | -D/O                                    | of por Othe                                                    |                                          | th (Check only o                      |                                                 |                                                                 |
| on of                      | To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page                                                                                                                                                                                                     | ition: To           | 27. Manner of Death  1 Matural 5 Pending 2 Accident investigation                                                                 | 28a. Date of Injury<br>(Month, Day Year)                                                          | ER/Outpatient<br>28b. Time of<br>Injury | 28c. Injury<br>Work                                            |                                          |                                       | dence 6 Other (Spenow injury occurred           | ecity)                                                          |
| Divis                      | Hospitel or Attence     A hours after death     Funerel Director: etely filled in by the                                                                                                                                                                                                                                                                                           | Certification:      | 3 Surcide 6 Could not be<br>4 Homicide determined                                                                                 | 28e. Place of Injury - At hos<br>building, etc. (Specify                                          | me, farm, stre                          | et, factory, office                                            |                                          | 28f. Location (S<br>City or Tox       | Street and Number or Fi<br>vn, State)           | Bural Route Number,                                             |
|                            | To the Hospitel within 24 hours and the Funerel completely filled                                                                                                                                                                                                                                                                                                                  | edical (            | 29a. Certifier (Check only one) Certifying Ph                                                                                     | ysicien: To the best of my know<br>iner: On the basis of examinat<br>and manner stated.           | vledge, death<br>ion and/or inv         | occurred at the timestigation, in my op                        | ne, date and place<br>pinion, death occu | , and due to the<br>rred at the time, | cause(s) and manner a<br>date and place, and du | s stated.<br>e to the cause(s)                                  |
|                            | To the within 2 To the complet                                                                                                                                                                                                                                                                                                                                                     | M                   | 29b. Signature and title of certifier                                                                                             |                                                                                                   | -                                       | 29c. License                                                   |                                          |                                       | 29d. Date signed (Mon                           | th, Day, Year)                                                  |
|                            | . 1                                                                                                                                                                                                                                                                                                                                                                                |                     | 30. Name and address of person who                                                                                                |                                                                                                   | 220) /7: 5                              | D (                                                            | 47643<br>Nowa M                          |                                       | 2/27/08                                         |                                                                 |
|                            | H                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                   |                                                                                                   |                                         | s Rent                                                         | nows M                                   | D 2113                                | 6                                               |                                                                 |
|                            | Sta<br>Registr                                                                                                                                                                                                                                                                                                                                                                     | - 8                 | Payment Mills 25 31. Date fled (Month, Day, Year) FEB 2 8 2008                                                                    | 32. Registrar's Signat                                                                            | of south                                |                                                                |                                          |                                       |                                                 |                                                                 |
| 4                          |                                                                                                                                                                                                                                                                                                                                                                                    | 100                 | FED TO COMO                                                                                                                       | 63000                                                                                             | #                                       |                                                                |                                          |                                       |                                                 |                                                                 |

1 - For Stete Registrer

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

| ^" | ٠ | ٠, | 9.0 | 17 | $\cap$ | $\cap$ | 0    |
|----|---|----|-----|----|--------|--------|------|
|    |   |    |     | /  | 1.5    | 1 1    | 30 1 |
|    |   |    | O   |    | 1 )    | 1 1    | 1 2  |

Year

2. Date of Death

Month

3. Time of Death

1 √ Yes 2 No

Year

29d. Date signed (Month, Day, Year)

02-14-08

Square Prive, Bultimore, MD. 21237

| Physici<br>/Medic<br>Examin | al |
|-----------------------------|----|
| Funeral                     |    |

Director

ð

Completed

Be

"neturel", or Items 23e 2 should be f and Mental I is marked Department of Health a Important: If item 27 Is any injury or other trai

Physician /Medical Examiner

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical þ Completed To the Hospitel or Attending Physician: Be this Certification: within 24 hours after death.

To the Funerel Director; All completely filled in by the fu filled in by

Jerimiah Hunt II tebruary 14 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death KOSECQUE If Under 1 Year | If Under 24 Hrs. transsin Square Hospital Center TIMORE 8. Date of Birth (Month, Day, Year) Feb 14, 2008 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number Days 1 ☑ M 2 □ F Maryland none Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b Counts 10c. City, Town or Location MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21219 USA 35 Loring Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) hone none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Ashiya Cartwright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9000 Franklin Square Drive Rosedale, MD 21237 Franklin Square Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State `4 □Donation 5 🛛 Other (Specify) in state. 21. Signature of Euneral Service Wensae Rolaid . Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 m Approximate Interval Between Onset and Death 28a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. +mmgturity Due to (or as a consequence of ture of membranes emature Sequentially but conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use centribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

4 Homicide

Dr. Mario

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 2 8

algout k

30. Name and addr ss f person who compared cause of death (Item 23a) (Type, Print)

Chanem

29a. Certifier (Check only one)

9000 Franklin

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness and due to the cause(s) and mainteness of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

KES 000 0

|                                            |                                                                                                                                                                                                                                                                      |                  | 1 - For<br>State<br>Registrar                                                 | State of Ma                                    | ryland              |                            | artmen<br><i>tificat</i>              |                      |                           | ind Me        |                                      | gienę<br>Rog. No | 008                             | 06151                                              |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------|------------------------------------------------|---------------------|----------------------------|---------------------------------------|----------------------|---------------------------|---------------|--------------------------------------|------------------|---------------------------------|----------------------------------------------------|
|                                            |                                                                                                                                                                                                                                                                      |                  | Decedent's Name (First, Middle, Last)                                         |                                                |                     |                            |                                       |                      |                           | 1:            | 2. Date of Dea                       | ath              |                                 | 3. Time of Death                                   |
|                                            | Physici<br>/Medic                                                                                                                                                                                                                                                    |                  | Gertrude A. Hyman                                                             |                                                |                     |                            |                                       |                      |                           |               | Month<br>02-22-2                     | 2008             | Year                            | 1:00 a M                                           |
|                                            | Examin                                                                                                                                                                                                                                                               |                  | 4a. Facility Name (If not institution, give                                   | street and number)                             |                     |                            | 4b. City,                             | Town, or L           | ocation of                | f Death       |                                      | 4c.              | County of Deat                  |                                                    |
|                                            |                                                                                                                                                                                                                                                                      |                  | Brightview Assist                                                             |                                                |                     |                            |                                       | 1 Ai                 |                           |               |                                      |                  | Harford                         |                                                    |
|                                            | Funeral<br>Director                                                                                                                                                                                                                                                  |                  | 5. Social Security Number 6. Security 1219–16–4273                            | 7. Age                                         | (In yrs. las        | t birthday)<br>Yrs.        | If Under<br>Months                    | 1 Year<br>Days       | Hours                     | Min.          | B. Date of Birth (Month, Day 1-09-19 | 7. Year)         | 9. Birt<br>Co<br>Mary           | hplace (State or Foreign<br>untry)<br>1and         |
|                                            | pur M                                                                                                                                                                                                                                                                |                  | Usual Residence of Decedent  10a, State 10b, County                           |                                                | 10c. City, 1        | Town or Lo                 | cation                                |                      |                           |               |                                      |                  |                                 | 10d. Inside City Limits                            |
|                                            | Aaryli<br>Ceho                                                                                                                                                                                                                                                       | ō                | Maryland Harford                                                              |                                                |                     | 1 Air                      |                                       |                      |                           |               |                                      |                  |                                 | 1 ☐ Yes 2 <b>7</b> No                              |
|                                            | 28a-                                                                                                                                                                                                                                                                 | rect             | 10e. Street and Number                                                        |                                                | БС.                 | 1 1111                     | 10f. Zip                              | Code                 |                           |               |                                      | 10g. Citiz       | zen of What Co                  | untry?                                             |
|                                            | 3a or                                                                                                                                                                                                                                                                | Funeral Director | 1300 H. Scottsdale                                                            | Drive                                          |                     |                            | 2                                     | 1015                 |                           |               |                                      |                  | S.A.                            |                                                    |
|                                            | death                                                                                                                                                                                                                                                                | nera             | 11. Marital Status                                                            | 12. Was Decedent E<br>Armed Forces?            | ver in U.S.         | 13. \                      | Vas Deced                             | dent of His          | panic Orig                | in? (Spec     | ify Yes or No-<br>ican, etc.)        | . 1              | 14. Race - Ame                  |                                                    |
| 9                                          | or Ite                                                                                                                                                                                                                                                               | /Fu              | 1 Never Married 2 Married                                                     | 1 Yes 2 No                                     | 0                   |                            | ires, spec<br>1 □ Yes                 |                      | Specify:                  | , rueito n    | ican, etc.)                          | i                | Black, White<br>Specify:        | B, BTC.                                            |
| 200                                        | urel',                                                                                                                                                                                                                                                               | d by             | 3X Widowed 4 □ Divorced                                                       | Year or Dates:                                 |                     |                            |                                       |                      |                           |               |                                      |                  | W                               | hite                                               |
| ה<br>ה                                     | "nat                                                                                                                                                                                                                                                                 | iete             | 15. Decedent's Edu<br>(Specify only highest grad                              |                                                |                     | 16a. Deced<br>Give         | ient's Usua<br>kind of wo<br>DO NOT u | rk done du           | ion<br><i>Iring m</i> ost | of working    | 9                                    | 16b. Kir         | nd of Business/                 | Industry                                           |
| 7                                          | filed within 72 hours after death with the Maryland<br>Hygiene, then "naturel", or Iteme 23e or 28e-f ehow<br>ent, the Maccal Examiner must be notified a                                                                                                            | Completed        | Elementary/Secondary (0-12)                                                   | College (1-4or 5+                              | <b>+</b> )          |                            | maker                                 |                      |                           |               |                                      | Ot               | wn Home                         |                                                    |
| 3                                          | Hyg<br>other                                                                                                                                                                                                                                                         | BeC              | 17. Father's Name (First, Middle, Last)                                       |                                                |                     |                            |                                       |                      | 18. Mother                | r's Name      | (First, Middle,                      |                  |                                 |                                                    |
| 0                                          | Alenta<br>Alenta<br>rked<br>rked                                                                                                                                                                                                                                     | To B             | Frances Gaeng                                                                 |                                                |                     |                            |                                       |                      | Elea                      | nor '         | Tragese                              | er               |                                 |                                                    |
|                                            | is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. He was them 23a or 28a-1 show them 21a ranked other then "naturel", or Items 23a or 28a-1 show other treumstic event, the Madical Exemple in use the notified. |                  | 19a. Informant's Name/Relationship (Ty                                        |                                                |                     |                            | •                                     |                      |                           |               |                                      |                  | Town, State, 2                  | Zip Code)                                          |
|                                            | and sand m 27 m 27 her tr                                                                                                                                                                                                                                            |                  | George Hyman (Son                                                             | )                                              | Jasi Bi             |                            |                                       |                      | t Bel                     |               | , MD 21                              |                  |                                 |                                                    |
| 5                                          | ges 1<br>if it of H<br>if ite<br>or oth                                                                                                                                                                                                                              |                  | 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ F                      | emoval from State                              | 20b. Plac           | e of Dispo<br>letery, cren | sition (Nar<br>natory or c            | ne of<br>ther place, | ) į                       | Da            | te                                   | 20c. Lo          | cation - City or                | Town, State                                        |
| altimor                                    | t. Par<br>ntmen<br>rtant:<br>njury                                                                                                                                                                                                                                   |                  | 4 Donation 5 Other (Specify)                                                  |                                                | St.                 | Igna                       | tius                                  | Cem.                 |                           | 2-26          | -2008                                | Hicl             | kory, M                         | aryland                                            |
| D D                                        | permit. Pages 1 an<br>Department of Heal<br>Important: if Item 2<br>any Injury or other<br>once.                                                                                                                                                                     |                  | 21, Signature of Funeral Service Lioens                                       | ne Q                                           | <u>م</u> ــــــــــ | In                         | . Name ar<br>с. 61                    | O W.                 | Mac P                     | Schii<br>ahil | nunek E<br>Rd Bel                    | Tune:<br>L Ai:   | ral Hom                         | e of Bel Air<br>1014                               |
|                                            |                                                                                                                                                                                                                                                                      |                  | 23a. Part1, Enter the disease, or compleshock, or heart failure. List only or | cations that caused the cause diesections      | the death.          | Do not ent                 | er the mod                            | le of dying,         | such as c                 | cardiac or    | respiratory ari                      | rest,            |                                 | Approximate<br>Interval Between<br>Onset and Death |
| F                                          | hysician                                                                                                                                                                                                                                                             |                  | Immediate Cause (Final disease or condition resulting in death)               | +1-                                            | Zha                 | Zine                       | 15                                    | da                   | ente                      | ن             |                                      |                  |                                 | (Lews)                                             |
|                                            | /Medical<br>Examiner                                                                                                                                                                                                                                                 |                  | resulting in dealth)                                                          | Due to (or as a                                | consequer           | nce of):                   |                                       |                      |                           |               |                                      |                  |                                 | 7                                                  |
|                                            |                                                                                                                                                                                                                                                                      | 9.               | Sequentially list conditions, if any, leading to immediate                    | Due to (or as a                                | consequer           | nce of):                   |                                       |                      |                           |               |                                      |                  |                                 |                                                    |
|                                            | uted<br>d<br>ansit                                                                                                                                                                                                                                                   | Examiner         | cause. Enter Underlying Cause (Disease or injury that initiated events        |                                                |                     |                            |                                       |                      |                           |               |                                      |                  |                                 |                                                    |
| 'n                                         | exec<br>en an                                                                                                                                                                                                                                                        |                  | resulting in death) Last                                                      | Due to (or as a                                | consequer           | nce of):                   |                                       |                      |                           |               |                                      |                  |                                 |                                                    |
| ,0070                                      | cate be executed oblysicien and the burial-transit                                                                                                                                                                                                                   | dicai            |                                                                               |                                                |                     |                            |                                       |                      |                           |               |                                      |                  |                                 |                                                    |
| ğ                                          | e as t                                                                                                                                                                                                                                                               | Med              | IF FEMALE:                                                                    |                                                |                     |                            |                                       |                      |                           |               |                                      |                  |                                 |                                                    |
| ֪֞֝֟֝֟֝֟֝                                  | ath ca                                                                                                                                                                                                                                                               | Physician/Med    | 23b. Was decedent pregnant in the past 12 months?                             | 3c. If yes, outcome o                          | 2 ☐ Fetal de        | eath 3                     | Ectopic p                             |                      |                           |               |                                      | 2                | 3d. Date of del<br>Month        | ivery<br>Day Year                                  |
| 5                                          | the e                                                                                                                                                                                                                                                                | ysic             | 1 ☐ Yes 2 No<br>9 ☐ Unknown                                                   | 4□ Pregnant at t<br>9□ Unknown                 | ime or deat         | in 5∟                      | Other (sp                             | өспу)                |                           |               |                                      |                  |                                 |                                                    |
| Ĺ                                          | The law requires that the death certific<br>are hes been signed by the ettending p<br>pege 2 should be detached for use as                                                                                                                                           |                  | Part If. Other significant conditions cor                                     | ntributing to death but                        | t not resulții      | ng in the ur               | nderlying o                           | ause giver           | n in Part f.,             |               | 23e. Did to                          | bacco u          | se contribute to                | the cause of death?                                |
| 5<br>5<br>-                                | n sign                                                                                                                                                                                                                                                               | d by             | atrial fibrille                                                               | the che                                        | sent                | com.                       |                                       |                      |                           |               | 1 🗆 Y                                | es 25            | No 3□Pr                         | obably 4 Unknown                                   |
| 3                                          | s bee                                                                                                                                                                                                                                                                | ojet             |                                                                               | (                                              | , (                 |                            |                                       |                      |                           |               | 24a. Was                             |                  | 24b. Were au                    | itopsy findings available                          |
| ֡֟֝֟֝֟֝֟֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֡֓֓֓֓֓֡֓֡֓ | rne is                                                                                                                                                                                                                                                               | Completed        |                                                                               |                                                |                     |                            |                                       |                      |                           |               | autop<br>perfor<br>1 Yes             |                  | death?                          | completion of cause of                             |
|                                            | ntifice<br>ctor, p                                                                                                                                                                                                                                                   | Be C             | 25. Was case referred to medical examiner?                                    |                                                |                     |                            |                                       |                      | 26. Place                 | of Death      | (Check only or                       |                  |                                 |                                                    |
| > ·                                        | nysic<br>his ce<br>I dire                                                                                                                                                                                                                                            | To               | 1 ☐ Yes 2 No                                                                  | lospital: 1 🔲 fnpatien                         | nt 2 EF             | NOutpatien                 |                                       |                      | 4 DO NUI                  | rsing Hom     | e 5 🗆 Resid                          | ience 6          | Other (Spe                      | cify)                                              |
|                                            | Ing P                                                                                                                                                                                                                                                                | E O              | 27. Manner of Death 1 □Natural 5 □ Pending                                    | 28a. Date of fnjury<br>(Month, Day             |                     | 8b. Time of<br>Injury      |                                       | 8c. Injury<br>Work?  |                           |               | 3d. Describe h                       | now injury       | y occurred                      |                                                    |
| NISION :                                   | death<br>death<br>tor: /<br>the f                                                                                                                                                                                                                                    | cat              | 2 Accident investigation 3 Suicide 6 Could not be                             | Go. Blood of leiter                            | - At Land           |                            | М                                     |                      | es 2 🗆 N                  |               | Of Leasting (C                       | Chront on        | d Alumbar or C                  | ıral Route Number,                                 |
| <u> </u>                                   | after after Direct                                                                                                                                                                                                                                                   | Certification;   | 4 Homicide determined                                                         | 28e. Place of Injurbuilding, etc.              | (Specify)           | e, rami, str               | eet, ractory                          | /, опісе             |                           | 2             | City or Tow                          | vn, State)       | )                               | nar noute wurnber,                                 |
|                                            | To the thours after date within 2 hysician: The law within 24 hours after discrete this certificate hes To the Funeral Director; After this certificate hes completely filled in by the funeral director, page 2                                                     | edicai C         | 29a. Certifier (Check only one) Certifying Physical Exami                     | sician: To the best of<br>ner: On the basis of | examination         | edge, death                | n occurred<br>vestigation             | at the time          | e, date and               | d place, ar   | nd due to the o                      | cause(s)         | and manner as<br>place, and due | stated.<br>to the cause(s)                         |
| :                                          | o the<br>o the<br>omple                                                                                                                                                                                                                                              | Med              | 29b. Signature and title of certifier                                         | and manner stat                                |                     |                            | 290                                   | . License            | number                    |               |                                      | 29d. Day         | e signed (Mont                  | h, Day, Year)                                      |
|                                            | - 3 <del>-</del> 3                                                                                                                                                                                                                                                   |                  | PALL M                                                                        | S                                              |                     |                            | 1                                     | 20                   | 122                       | 7             | 1                                    | 21               | 26/2                            | 18                                                 |
|                                            | 10                                                                                                                                                                                                                                                                   |                  | 30. Name and address of person who co                                         | mpleted cause of de                            | ath (Item 2         | За) (Туре.                 | Print)                                | A1                   |                           |               |                                      | -                |                                 |                                                    |
|                                            |                                                                                                                                                                                                                                                                      |                  | PATRICIA DU                                                                   | भगरा भ <u>ी</u>                                | 6                   | 5 1                        | 7. W                                  | -CP                  | ul                        | LL            | bel A                                | · W              | IP ZUS                          | 14                                                 |
|                                            | Sta<br>Registr                                                                                                                                                                                                                                                       |                  | 31. Date filed (Month, Day, Year)                                             | 32. Registra                                   | r's Signatur        | · e                        | · A                                   | and i                | ,                         |               |                                      |                  |                                 |                                                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EBRUARY Day 7, 2000B **Physician** ALICE ESTELLA NAYLOR HELD 12:36 AM /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 216-07-2088 1 □ M 2 🔯 F 88 Director Apr 18, 1919 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the M. dical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore County Towson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Avenue, #1218 21204 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify White þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Telecommunications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grover Cleveland Naylor ဂ္ Cora Estella Bul1 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Hazel Butler (Sister) 302 E. Joppa Road, Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Prospect Hill Cemetery 3/1/08 Towson, Maryland 21. Signature of Funcial Service University (1) See

22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21212

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately Cause (Fire) 21. Signature of Funeral Services Union

Martin D. Lawson Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): BRADYCARDIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner HYPOTENSION Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 1 ☐ Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

Box 68760, P.0.

3altimore, Maryland 21215-0036

Pages 1

certificate be executed physician and s the burial-trans as nse for signed by the a Division or Vital Records, certificate has been si rector, page 2 should uneral director,

To the Hospita, c. within 24 hours after death.
To the Funeral Director: After a constant of the function of t

State

Medical

[3]

31. Date filed (Month, Day, Year)

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D39215

7601 OSLER DRIVE,

108

MARYLAND 21204

NOON

28

TOWSON.

DHMH 17 Rev 1/2001

Registrar

ma address of person who completed cause of death (Item 23a) (Type, Print)

32. Reģistrar's Signature

Ligar Marie Marie

CUNNINGHAM M.D.,

FEB 2 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9:17AM chael Hope ebruary 2008 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) fown or Location of Death Examiner Baltimore The Johns Hopkins Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) . Age (In vrs. last birthday) **Funeral** Days Hours **X**□M 2□F 215-52-4076 4-14-1951 Director 56 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If Item 27 Is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examiner must be notified at MD N/A 1√DYes 2 No Baltimore Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 1400 N. Linwood Avenue 21213 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Yes 2000 If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Steel College (1-4or 5+) Bethlehem Elementary/Secondary (0-12) Mobile Equipment 12th grade N/AOperator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 1 f Health and Menta Item 27 Is marked ై Clarence Rice Mildred Hope 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bessie Hope - Wife 1400 N. Linwood Avenue Balto, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 2-27-08 Randallstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H East 1101 E. North Avenue Balto, Md 21202 Moon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Asystole 40 min /Medical Due to (or as a consequence of): Examiner Disease oronau Artury Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit years Hypertension Due to o as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Livshits, Medical Doctor Res - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Livshits

FEB 28

2008

The Johns Hopkins Hospital, 600 North Wolfe Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day 20:51p<sup>M</sup> FEBRUARY 17, 2008 TERESA DELORES SMITH HILL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CLINTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1 □ M 2 🕱 F 55 Yrs. Months Director 03-12-1952 578-68-3537 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Prince George's Forestville 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2313 Wintergreen Avenue 20747 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Š If Yes, Give Year or Dates: Specify. Specify: Black nan "natural", o Medical Exar 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry A should be filed within 72 and Mental Hygiene.

7 Is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Nursing Assistant Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Briscoe Dorothy Briggman 2 traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is in any Injury or other traum Regina D. McFadden/Daughter 721 Harry S. Truman Drive, #112, Largo, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Washington NationalCem 02-22-2008 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. DICKO SUITLAND, MD 20746 4308 SUITLAND ROAD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atherosclerotic Cardiovascular Disease unknown /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-tran and Due to (or as a consequence of) Box 68760, nding physician Physician/Medical the use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) signed by the a P.0. I Ves 2 No XX Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, <u>م</u> Chronic Liver Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Hepatitis C 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1□ Yes XX No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) XXInpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 3 ☐ No ျ this 27. Manner of Death XX Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division 5 Pending investigation spital or Attendinours after death.

neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Hospital \*\*XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 50454 02/19/2008 30. Name and address of person who compl d cause of death (Item 23a) (Type, Print) Arastoo Yazdani, 9400 Livingston Road Suite 3-350, Fort Washington, MD 20744 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

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|     | Baltimore, Maryland 21215-0036                                                      |          |  |
|-----|-------------------------------------------------------------------------------------|----------|--|
| Ph  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland | ı        |  |
| ys  | Department of Health and Mental Hygiene.                                            | Fi<br>Di |  |
| sic | Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show    | ın<br>re |  |
| :ia | any Injury or other traumatic event, the Medical Examiner must be notified at       | er<br>ct |  |
| n   | once.                                                                               | a        |  |

/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, Regis

|                | •                                                                                                                    | For<br>State<br>Registrar                                                                                                                                                                                                                              |                     |                   | orate o              | i iviai yie                                  |                            | Certific                   |                                     |                                        | i wentai ny                        |                                | .20           | 08                   | 05                       | 155            |
|----------------|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------|----------------------|----------------------------------------------|----------------------------|----------------------------|-------------------------------------|----------------------------------------|------------------------------------|--------------------------------|---------------|----------------------|--------------------------|----------------|
| nysicia        | 'n                                                                                                                   | 1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year  3. Time of Death  Month                                                                                                                                                  |                     |                   |                      |                                              |                            |                            |                                     |                                        |                                    |                                |               |                      |                          |                |
| Medic          |                                                                                                                      |                                                                                                                                                                                                                                                        |                     |                   |                      |                                              |                            |                            |                                     |                                        | Feb.                               | 23                             | 3 2           | 800                  | 6:25                     | P M            |
| xamin          | er                                                                                                                   | 4a. Facility Name (I                                                                                                                                                                                                                                   |                     |                   | reet and nur         | mber)                                        |                            | 4b. 0                      |                                     | or Location of De                      | ath                                | 4c. County of Death  Baltimore |               |                      |                          |                |
|                | ш                                                                                                                    | 13607 A13                                                                                                                                                                                                                                              |                     | 6. Sex            |                      | 7 Age (In s                                  | rs. last birth             | day) If Ur                 | Ba<br>nder 1 Year                   | 1dwin                                  | rs. 8. Date of B                   | irth                           | В             |                      | more                     | or Foreign     |
| neral<br>ector | 214-26-1066 Usual Residence of Decedent  1 ☑ M 2 ☐ F 79  Yrs. Months Days Hours Min. (Month, Day, Year) Oct. 01 1928 |                                                                                                                                                                                                                                                        |                     |                   |                      |                                              |                            |                            |                                     |                                        | Oh                                 | untry)                         | e or r oreign |                      |                          |                |
| #              |                                                                                                                      | 10a. State                                                                                                                                                                                                                                             | 10b. Count          | ty                |                      | 10c.                                         | City, Town                 | or Location                |                                     |                                        |                                    |                                |               |                      | 10d. Inside              | City Limits    |
| fied           | ţō                                                                                                                   | MD                                                                                                                                                                                                                                                     | Balti               | more              |                      |                                              | Bald                       | lwin                       |                                     |                                        |                                    |                                |               |                      | 1 □ Y€                   | es XII No      |
| поп            | irec                                                                                                                 | 10e. Street and Nu                                                                                                                                                                                                                                     | mber                |                   |                      |                                              |                            | 10f.                       | . Zip Code                          |                                        |                                    | 10g. C                         | itizen of W   | /hat Cou             | untry?                   |                |
|                | al                                                                                                                   | 13607 A                                                                                                                                                                                                                                                | llisto              | n Dr.             |                      |                                              |                            |                            | 2                                   | 1013                                   |                                    | i                              | USA           | A                    |                          |                |
|                | d by Funeral Director                                                                                                | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?                                                                                                                                                                                         |                     |                   |                      |                                              |                            |                            | ecedent of I                        | Hispanic Origin?<br>van, Mexican, Pu   | (Specify Yes or Nerto Rican, etc.) | lo-                            |               | e - Amer<br>k, White | rican Indian,<br>e. etc. |                |
|                |                                                                                                                      | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates                                                                                                                                                                                   |                     |                   |                      |                                              | No 1 ☐ Yes 2 ☑ No Specify: |                            |                                     | ,                                      | Specify:                           |                                |               | White                | 2                        |                |
|                | etec                                                                                                                 | (Spec                                                                                                                                                                                                                                                  | 15. Decede          | ent's Educa       | ation<br>completed)  |                                              | 1 (                        | ecedent's l<br>Give kind o | f work done                         | during most of w                       | vorking                            | 16b.                           | Kind of Bu    | siness/li            | ndustry                  |                |
|                | Jd m                                                                                                                 | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)                                                                                      |                     |                   |                      |                                              |                            |                            |                                     |                                        |                                    | _                              |               |                      |                          |                |
|                | Ŝ                                                                                                                    | 12 Eathor's Name                                                                                                                                                                                                                                       | (Eirot Middle       | 2 / act)          | 1                    |                                              | Mech                       | nanica                     | ıl Eng                              | ineer                                  | ame (First, Middl                  |                                |               |                      | Conti                    | racts          |
|                | Be                                                                                                                   | 17. Father's Name                                                                                                                                                                                                                                      |                     | -                 | 1                    |                                              |                            |                            |                                     |                                        | Mae Bur                            |                                |               | θ)                   |                          |                |
|                | ၉                                                                                                                    | William  19a. Informant's N                                                                                                                                                                                                                            |                     |                   |                      |                                              | 10h I                      | Mailing Add                | zona /Ctron                         |                                        | Rural Route Num                    |                                |               | Ctato 7              | in Cada)                 |                |
|                |                                                                                                                      | Patricia                                                                                                                                                                                                                                               |                     |                   | *                    |                                              | 11                         | Sylv                       | anhur                               |                                        | Notting                            | -                              |               |                      |                          |                |
|                |                                                                                                                      | 20a. Method of Dis<br>N☐ Burial 2                                                                                                                                                                                                                      |                     | ı 3∐Re            | moval from           |                                              | b. Place of E<br>cemetery, | Disposition (<br>crematory | (Name of<br>or other pla            | ce) 2/2                                | 29 <sup>Date</sup> 8               | 20c. l                         | Location -    | City or 1            | Town, State              |                |
| 1              |                                                                                                                      | 4 Donation                                                                                                                                                                                                                                             | 5 Other (           | (Specify)         |                      |                                              | u1aney                     |                            |                                     | morial (                               | Gardens                            | Tim                            | oniun         | n, M                 | D                        |                |
| ouce           |                                                                                                                      | 21. Michae                                                                                                                                                                                                                                             | 2                   | Flag1             | 10                   | <u>}                                    </u> |                            | Len                        | mon F                               | ess of Facility<br>uneral I<br>onia Rd | Home of I                          | Dula<br>ium,                   | ney V         | /a11<br>2109         | ey, In                   | nc.            |
|                |                                                                                                                      | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death |                     |                   |                      |                                              |                            |                            |                                     |                                        |                                    |                                |               |                      |                          |                |
| n              |                                                                                                                      | Immediate Cause                                                                                                                                                                                                                                        | (Final              |                   | pro                  | stal                                         | D (                        | an                         | cer                                 |                                        |                                    |                                |               | 1                    | Onset an                 | id Death<br>പോ |
| ıl             |                                                                                                                      | resulting in death)                                                                                                                                                                                                                                    |                     | Ca.               | Due to               | (or as a con                                 | sequence of                | ):                         |                                     |                                        |                                    |                                |               |                      | 7                        |                |
| r              |                                                                                                                      | Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):                                                                                                                                                        |                     |                   |                      |                                              |                            |                            |                                     |                                        |                                    |                                |               |                      |                          |                |
| -              | iner                                                                                                                 | if any, leading to in<br>cause. Lines once<br>Cause (Disease or                                                                                                                                                                                        | nmediate            | Į                 | Due to               | (or as a con:                                | sequence of                | ):                         |                                     |                                        |                                    |                                |               |                      |                          |                |
| 1              | Examiner                                                                                                             | that initiated events<br>resulting in death)                                                                                                                                                                                                           | injury<br>S<br>Last | c.                | Dunte                | /                                            | sequence of                | \.                         |                                     |                                        |                                    |                                |               |                      |                          |                |
|                | al<br>E                                                                                                              | , , , , , , , , , , , , , , , , , , , ,                                                                                                                                                                                                                |                     | -                 | Due to               | (or as a cons                                | sequence or                | ),                         |                                     |                                        |                                    |                                |               |                      |                          |                |
|                | edical                                                                                                               |                                                                                                                                                                                                                                                        |                     | d.                |                      |                                              |                            |                            |                                     |                                        |                                    |                                |               |                      |                          |                |
|                |                                                                                                                      | IF FEMALE:                                                                                                                                                                                                                                             |                     | 23                | c. If yes, out       | tcome pf pre                                 | egnancy                    |                            |                                     |                                        | HIII a                             |                                | 23d. Dat      | e of deli            | iverv                    |                |
|                | Physician//                                                                                                          | in the past 12                                                                                                                                                                                                                                         | months?             |                   |                      | oirth 2 🗆 F                                  |                            |                            | ic pregnand<br>r <i>(specify)</i> _ | у                                      |                                    |                                | Mo            |                      | Day                      | Year           |
|                | ysi                                                                                                                  | 1 ☐ Yes 2 ☐<br>9 ☐ Unknown                                                                                                                                                                                                                             |                     |                   | 9□Unkn               |                                              |                            |                            | ,,,,,                               |                                        |                                    |                                |               |                      |                          |                |
|                | by Pi                                                                                                                | Part II. Other signi                                                                                                                                                                                                                                   | ficant condi        | tions cont        | ributing to de       | eath but not                                 | resulting in t             | he underlyi                | ng cause gi                         | ven in Part I.                         | 23e. Did                           | I tobacco                      | use conti     | ribute to            | the cause o              | of death?      |
|                | g<br>D                                                                                                               | Jus                                                                                                                                                                                                                                                    | rerte               | nel               | on                   |                                              |                            |                            |                                     |                                        | 1 [                                | Yes                            | 2 Day         | 3 □ Pro              | obably 4 [               | □Unknown       |
| 1              | Completed                                                                                                            | ' (/                                                                                                                                                                                                                                                   |                     |                   |                      |                                              |                            |                            |                                     |                                        | 24a. Wa                            |                                |               |                      | itopsy finding           |                |
|                | mc                                                                                                                   |                                                                                                                                                                                                                                                        |                     |                   |                      |                                              |                            |                            |                                     |                                        | _ per                              | opsy<br>formed?                | 1 6           | death?               | completion of            | f cause of     |
| - 1            | O                                                                                                                    | 25. Was case refer                                                                                                                                                                                                                                     | red to medic        | al                |                      |                                              |                            |                            |                                     | 26. Place of D                         | 1□ Yes<br>eath (Check only         |                                | Ψ0            | Yes                  | 2□ No                    |                |
| - 1            | 0 0                                                                                                                  | examiner?                                                                                                                                                                                                                                              | No                  |                   | spital:              | Inpatient 2                                  | 2 🗌 ER/Outp                | atient 3                   | DOA Ot                              | hor:                                   | Home 5                             | _                              | 6 ∏Oth        | er (Spec             | cify)                    |                |
|                | μ                                                                                                                    | 27. Manner of Dear                                                                                                                                                                                                                                     |                     |                   | 28a. Date            |                                              | 28b. Tir                   |                            | 28c. Inju                           | iry at                                 | 28d. Describe                      |                                |               | , ,                  |                          |                |
|                | atio                                                                                                                 | 2 ☐ Accident                                                                                                                                                                                                                                           | 5 ☐ Pend<br>inves   | ling<br>stigation | (IVIOII              | ui, Day rea                                  | "   ""                     | M                          | 1                                   | Yes 2 No                               |                                    |                                |               |                      |                          |                |
|                | Certification:                                                                                                       | 3 ☐ Suicide<br>4 ☐ Homicide                                                                                                                                                                                                                            | 6 □ Could<br>deter  | d not be<br>mined | 28e. Place<br>buildi | of injury - A<br>ing, etc. (Sp               | At home, farn              | n, street, fa              | ctory, office                       |                                        | 28f. Location<br>City or T         |                                |               | er or Ru             | ıral Route N             | umber,         |
|                |                                                                                                                      | 29a. Certifier                                                                                                                                                                                                                                         | Certify             | ing Physi         | clan: To the         | best of my                                   | knowledge,                 | death occu                 | rred at the t                       | ime, date and pla                      | ace, and due to th                 | ie cause                       | (s) and ma    | ınner as             | stated.                  |                |
|                | edical                                                                                                               | (Check only one)                                                                                                                                                                                                                                       | ∠ wiedica           | ar Examine        | and man              | ner stated.                                  | nination and               | or investiga               | ation, in my                        | opinion, death of                      | ccurred at the time                | e, date a                      | end place,    | and due              | to the caus              | ie(s)          |
|                | Σ                                                                                                                    | 29b. Signature and                                                                                                                                                                                                                                     | title of certifi    | ier C             | -)1.                 |                                              |                            |                            | 29c. Licen                          |                                        | 7                                  |                                | ate signe     | 1 (Month             | h, Day, Year             | r)             |
|                |                                                                                                                      |                                                                                                                                                                                                                                                        | w                   | sa                | M                    | ass                                          | aw                         | MO                         | ().                                 | 3643                                   | t                                  | 2                              | 12/1          | 08                   |                          |                |
|                |                                                                                                                      | 30. Name add                                                                                                                                                                                                                                           |                     |                   |                      | se of death                                  | Item 23a) (T               | ype, Print)                | ,                                   | 1 -                                    | 7<br>217775                        | CA                             | 0             | 142-5-01             |                          |                |
|                |                                                                                                                      | 334                                                                                                                                                                                                                                                    | W V V               | PER               |                      | C K                                          | a 2                        | 1113                       | (                                   | LU15K                                  | 4/1/+>                             | 24                             | KI            |                      |                          |                |
| Sta<br>jistra  |                                                                                                                      | 31. Date filed (Mor                                                                                                                                                                                                                                    | th, Day, Yea        |                   |                      | egistrar's Si                                | ignature                   | 1                          |                                     |                                        |                                    |                                |               |                      |                          |                |

**ORIGINAL** 

08-01576 Maura L. Hudson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ura L. Hudson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1              | State of Maryland / Department of Horor State  Certificate of Department |                                                                                                    | Reg. No. 2008 0615                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| Physicia<br>dical Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | n/             | 1. Decedent's Name (First, Middle,Last) Maura Latisha Hudson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Mo                                                                                                 | e of Death nth Day Year pruary 23, 2008  3. Time of Death 2343 hrs                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 4a. I don'ty Harrie (if flot motioned and see and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | City, Town, or Location of Death<br>Vestminster                                                    | 4c. County of Death Carroll                                                                              |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                | 5. Social Security Number 216-11-9505                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                    | ate of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD                                     |
| and<br>f show any<br>once,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | Usual Residence of Decedent  10a. State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                    | 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country?                                       |
| the Mary<br>3a or 28a-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Director       | 7112 Virginia Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0f. Zip Code<br>21784                                                                              | USA                                                                                                      |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | by Funeral     | 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Issey Year or Defects: 1 Yes 1 Yes 2 X No 1 Yes 1 Yes 1 Yes 2 X No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Decedent of Hispanic Origin? (Specify specify cuban, Mexican, Puerto Rican es 2 X No specify:      | , etc.) White, etc. specify: black                                                                       |
| 1036<br>vithin 72 hours<br>ene.<br>rr than "natur<br>Medical Exam                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Completed I    | Elementary/Secondary (0-12) College (1-4 or 5+) pupil p                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Usual Occupation (Give kind of work d<br>t of working life. DO NOT use retired)<br>ersonnel worker | Howard County<br>Public Schools                                                                          |
| 21215-0036<br>buld be filed within 7<br>Mental Hygiene,<br>marked other than<br>ic event, the Medica                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Be Co          | 17. Father's Name (First, Middle, Last) Gary Milton Hudson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | , Middle, Maiden Surname) $	ext{Kelly}$                                                            |                                                                                                          |
| MD 21 2 should h and Me 27 is mar umatic ev                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | To             | 19a. Informant's Name/Relationship (Type, Print) Genevieve Hudson (mother)  19b. Mailing A 7112 V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | irginia Ave., Syke                                                                                 |                                                                                                          |
| Baltimore, MD semit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Yother Specify: entombment Lake View                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Mausoleum 2-29-0                                                                                   | Sykesville, MD                                                                                           |
| Balti<br>permit.<br>Departu<br>Import<br>injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 21. Signature of Funeral Service Licensee P. C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | me and Address of Facility Haigh<br>. Box 195 Sykesvi                                              |                                                                                                          |
| Physician<br>/Medical<br>aminer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                    | Detween Shoet and                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | iner           | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                    |                                                                                                          |
| nted<br>d<br>ansit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Examin         | (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                    |                                                                                                          |
| 0,<br>the executed<br>sician and<br>burial - transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | edical         | UNPENDED AMENDED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                    | 23d. Date of delivery                                                                                    |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Physician/Me   | past 12 months?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | al death 3 Ectopic pregnancy<br>er (Specify)                                                       | Month Day Year                                                                                           |
| s, P.O. Be<br>ires that the de<br>signed by the<br>d be detached f                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | by Phy         | Part II. Other significant conditions contributing to death but not resulting in the un                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | nderlying cause given in Part I.                                                                   | 23e. Did tobacco use contribute to the cause of death?  1  Yes 2 ✓ No 3 Probably 4 Unknown               |
| of Vital Records, Is Physician: The law requires the this certificate has been signered in the control of the c | Completed      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    | 24a. Was an autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No |
| tal Rection: The certificate ector, page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Be Co          | 25. Was case referred to medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 26.Place of Death (Check only                                                                      |                                                                                                          |
| f Vita<br>Physici<br>er this co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ုင             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    | ome 5 Residence 6 Other:                                                                                 |
| on of<br>ending Pl<br>ath.<br>or: After<br>the funera                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | tion:          | 1 ✓ Natural 5 Pending 2 Accident Investigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1 Yes 2 No                                                                                         |                                                                                                          |
| Division  To the Hospital or Attendia within 24 hours after death. To the Funeral Director: /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, stree (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | t, factory, office building, etc. 28f                                                              | Location (Street and Number or Rural Route Number, City or Town, State)                                  |
| To the Hospi<br>within 24 hou<br>To the Function                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Medical C      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | red at the time, date and place, and due<br>ion, in my opinion, death occurred at the              | e to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)                  |
| To To Com                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Med            | and manner stated.  29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 29c. License number                                                                                | 29d. Date signed (Month, Day, Year) February 24, 2008                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 30. Name and address of person who completed cause of death (Item 23a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | O.C.M.E.                                                                                           |                                                                                                          |
| 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | Margarita Korell MD. Assistant Medical Examiner 111 P                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | enn Street, Baltimore, MD 212                                                                      | 201                                                                                                      |
| S<br>Regis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | 31. Date filed (Month, Day, Year)  FEB 2 8 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | a. 6. 9                                                                                            |                                                                                                          |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** Mildred Herr February 22, 2008 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4838 Aberdeen Avenue Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Yrs. Director 215-03-5252 May 1,1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1

Yes 2

No Director Maryland N/A Baltimore City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural" or items 23a or the Medical Examiner must be 4838 Aberdeen Avenue 21206 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: ⋛ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Years <u>Sales Lady</u> Retail permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygin Important: If Item 27 Is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Shaney Margarite Zick ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 4838 Aberdeen Ave. Baltimore, Maryland 21206 Mr. Frederick Herr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 2/25/2008 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to inf as a consequent of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner BRILLATION and certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria ANTERY DISEMIE ORUNA Physician/Medical as the IF FEMALE: nse 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Day Year ned by the and detached for 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown signed by the Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 MALTEIN 1 🗌 Yes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home F Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or

State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 2 8 2 2008

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who complete cause or death (Item 23a) (Type. MNI MO 32. Registrar's Signature

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 trances 02 25 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Columbia Howard Gen If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2X F 1921 Feb 13, 218 01 6415 87 Georgia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐Yes 2X No Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be 3698 Chateau Ridge Drive 21042 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 🏖 No ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) the Homemaker Own Home 12 permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important: If item 27 is marked other tany injury or other traumatic event. the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Minnie Lee Peacock Holmes Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3698 Chateau Ridge Drive Ellicott City, MD 21042 Elmer E. Homel/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 2-26-2008 Hanover, MD Ardent Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc, M01044 21. Signature of Funeral Service Licensee Gel 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPS13 Physician /Medical Due to (or as a consequence of): Examiner CHOLE CYSTISIS Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown Day for 5 ☐ Other (specify) ed by the a ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop. performe 2 2 No 1 Yes 26. Place of Death (Check only one) director. 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury 2 ER/Outpatient 3□ DOA 1 ☐ Yes Certification: To this filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? after death.

I Director: After the 27. Manner of De (Month, Day Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, doubt a state of the cause(s) and manner as stated.

P.O. Box 68760, Division or Vital Records, Hospital or Attending Physician: within 24 hours at To the Funeral C To the

Medical

State Registrar

son who completed cause of death (Item 23a) (Type, Print) JOYATHAN

D5/860

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of pe

Dr. # 200 10700 CHANTEN

31. Date filed (Month, Day, Year) FEB 2 8 2008

29a. Certifier

(Check only one)

29b. Signature and title of ce

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 25 2008 9:00 p February Cox Hardesty, Jr. Crumpton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist 8. Date of Birth (Month, Day, Year If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 6. Sex Social Security Number **Funeral** Days Months Hours 1 X M 2 □ F Maryland Jan 19. 88 1920 217-07-1931 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Ex miner must be notified at 1 ☐ Yes 2 X No Towson Baltimore Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21204 7001 N. Charles St. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give filed within 72 hours after 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White δ 3 ₩ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. General Mills Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental Harrison Grace Crumpton Cox Hardesty, Sr. other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health at Important: if item 27 is any injury or other trau 1823 Thorton Ridge Rd. Towson, Md. 21204 Mr. Daniel C. Hardesty/ Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-29-08 Hunningtown, Md. Calvary Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dyin L such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Inter the disease shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of P.O. Box 68760, Be Completed by Physician/Medical attending IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ung deslase 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes certificate 1∏ Yes To the Hospital or Attending Physician; 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Dice 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify P 1 TYes 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After t (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours after To the Funeral Dictor Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. (Check only one)

State

February 25,2001

rempton

31. Date filed (Month, Day, Year)

2008

28

FEB

29b. Signature and title of cortifier

Fegistrar's Signatu

who completed cause of death (Item 23a) (Type, Print)

6701

29c. License number

N. Chaste

29d. Date signed (Month, Day, Year)

Registrar

|                        |                                                                                                                                                                                                                                                                       |                   | 1- State of Maryla Registrar                                                                                                                                                                                                                     |                     | artment of H<br><i>rtificate of l</i>                    |                                                            | , 0                           | ene<br>                                              | 05160                                              |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------|------------------------------------------------------------|-------------------------------|------------------------------------------------------|----------------------------------------------------|
|                        | 10.0                                                                                                                                                                                                                                                                  | 3                 | Decedent's Name (First, Middle, Last)                                                                                                                                                                                                            |                     |                                                          |                                                            | 2. Date of Death              |                                                      | 3. Time of Death                                   |
|                        | Physici<br>/Medic                                                                                                                                                                                                                                                     | -                 | William Richard Hossler, Sr.                                                                                                                                                                                                                     |                     |                                                          |                                                            | Month<br>ebruary              |                                                      | 7:45 P.M                                           |
|                        | Examin                                                                                                                                                                                                                                                                | er                | 4a. Facility Name (If not institution, give street and number)                                                                                                                                                                                   |                     | 4b. City, Town, or<br>Westmi                             | Location of Death                                          |                               | 4c. County of Death                                  |                                                    |
| - 8                    |                                                                                                                                                                                                                                                                       |                   | 1205 Random Ridge Road  5. Social Security Number   6. Sex   7. Age (In y                                                                                                                                                                        | yrs. last birthday) | If Under 1 Year                                          |                                                            | B. Date of Birth              |                                                      | place (State or Foreign                            |
|                        | Funeral<br>Director                                                                                                                                                                                                                                                   |                   | 219-42-5001 1 M 2 F 63 Usual Residence of Decedent                                                                                                                                                                                               |                     | Months Days                                              | (Month, Day, 1                                             | n, Day, Year) Country)        |                                                      |                                                    |
|                        | laryland<br>show<br>ed at                                                                                                                                                                                                                                             | or                | 10a. State 10b. County 10c.                                                                                                                                                                                                                      | City, Town or Lo    |                                                          |                                                            |                               |                                                      | 10d. Inside City Limits 1 ☐ Yes 2 ☒ No             |
|                        | the N<br>28a-f<br>notifie                                                                                                                                                                                                                                             | Director          | Maryland Carroll W  10e. Street and Number                                                                                                                                                                                                       | lestmin.            | ster<br>10f. Zip Code                                    |                                                            | 10                            | g. Citizen of What Cou                               |                                                    |
|                        | th with<br>23a or<br>ust be r                                                                                                                                                                                                                                         | 'al Dir           | 1205 Random Ridge Rd.                                                                                                                                                                                                                            |                     | 21157                                                    |                                                            |                               | U.S.A.                                               |                                                    |
| 36                     | s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by Funeral        | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 □ No If Yes, Give Yea ☐ OP Res. — 1 9                                                                             |                     | Vas Decedent of H<br>f Yes, specify Cuba<br>1 □ Yes ※XVo | ispanic Origin? (Spec<br>in, Mexican, Puerto R<br>Specify: | ify Yes or No-<br>ican, etc.) | 14. Race - Americ<br>Black, White,<br>Specify: Whi   | etc.                                               |
| 21215-0036             | 72 hour<br>"natural<br>dical Ex                                                                                                                                                                                                                                       | Completed t       | 15. Decedent's Education (Specify only highest grade completed)                                                                                                                                                                                  | 16a. Deced          | dent's Usual Occup                                       | ation<br>during most of working<br>()                      | 1                             | 6b. Kind of Business/In                              |                                                    |
| 2121                   | 12 should be filed within 'n and Mental Hygiene.'<br>r is marked other than "r<br>raumatic event, <u>the Mec</u>                                                                                                                                                      | ршо               | Elementary/Secondary (0-12) College (1-4or 5+) 1 2                                                                                                                                                                                               |                     | chanic                                                   | "                                                          |                               | Farm Mach                                            | inerv                                              |
|                        | other<br>other<br>vent,                                                                                                                                                                                                                                               | BeC               | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                          |                     |                                                          | 18. Mother's Name (                                        |                               |                                                      |                                                    |
| Maryland               | uld b<br>Menta<br>rrked                                                                                                                                                                                                                                               | 일                 | William E. Hossler                                                                                                                                                                                                                               |                     |                                                          | Mary Ja                                                    | ane Wil                       | lhelm                                                |                                                    |
| lan                    | 2 sho<br>and I<br>is me                                                                                                                                                                                                                                               | Ì                 | 19a. Informant's Name/Relationship (Type. Print)                                                                                                                                                                                                 | 19b. Mailin         | ng Address (Street                                       | and Number or Rural                                        | Route Number,                 | City or Town, State, Zij                             | o Code)                                            |
|                        | s 1 and 2<br>if Health<br>Item 27 i                                                                                                                                                                                                                                   |                   | Cheryl Gereny - daughter                                                                                                                                                                                                                         |                     |                                                          |                                                            |                               |                                                      | MD. 2115                                           |
| Baltimore,             | Pages 1<br>nent of H<br>int: If Ite                                                                                                                                                                                                                                   |                   | 1 KBunal 2 Cremation 3 Removal from State                                                                                                                                                                                                        | -                   | sition (Name of<br>matory or other place<br>ns Ch. (     | i                                                          | -                             | oc. Location - City or T<br>008 Westm                | own, State<br>inster, MI                           |
| Balti                  | permit. Pages<br>Department of<br>Important: If It<br>any injury or once.                                                                                                                                                                                             |                   | 21. Signature of Funeral Service Licensee                                                                                                                                                                                                        | 22                  | 2. Name and Addres                                       | ss of Facility Eckl                                        | nardt E                       | Funeral C                                            | hapel P.A.                                         |
| NAME OF TAXABLE PARTY. | Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                     |                   | 23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequentially list conditions. | death. Do not ente  | er the mode of dyin                                      |                                                            | respiratory arres             |                                                      | Approximate<br>Interval Between<br>Onset and Death |
| 60,                    | ificate be executed  j physician and as the burial-transit                                                                                                                                                                                                            | I Examiner        | Sequentially list conditions, if any, leading to influente cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a conditions).                                                         |                     |                                                          |                                                            |                               |                                                      |                                                    |
| P.O. Box 68760,        | ath certi<br>ttending<br>or use a                                                                                                                                                                                                                                     | Physician/Medical | d                                                                                                                                                                                                                                                | Fetal death 3       | Ectopic pregnancy Other (specify)                        | ,                                                          |                               | 23d. Date of deliv<br>Month                          | very<br>Day Year                                   |
|                        | quires that the de<br>n signed by the a<br>lid be detached f                                                                                                                                                                                                          | þ                 | Part II. Other significant conditions contributing to death but not                                                                                                                                                                              | resulting in the ur | nderlying cause giv                                      | en in Part I.                                              | 23e. Did toba                 | acco use contribute to                               | the cause of death?                                |
| or Vital Records,      | The law requirate has been sixoage 2 should b                                                                                                                                                                                                                         | Completed         |                                                                                                                                                                                                                                                  |                     |                                                          |                                                            | 24a. Was an autopsy perform   | prior to co                                          | opsy findings available ompletion of cause of      |
| Ita                    | lysician: The iis certificate ha director, page                                                                                                                                                                                                                       | Bec               | 25. Was case referred to medical examiner?                                                                                                                                                                                                       |                     |                                                          | 26. Place of Death                                         |                               |                                                      |                                                    |
| <u> </u>               | Physician:<br>r this certificatal director, i                                                                                                                                                                                                                         | ၉                 | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient                                                                                                                                                                                                           | 2 ER/Outpatien      |                                                          | 4 🗆 Nursing Hom                                            |                               | nce 6 Other (Speci                                   | ify)                                               |
| Division (             | Attending<br>r death.<br>ector: After<br>by the fune                                                                                                                                                                                                                  | Certification:    | 27. Manner of Death  1                                                                                                                                                                                                                           | At home, farm, str  | M 1□                                                     | Yes 2 □ No                                                 |                               | w injury occurred<br>eet and Number or Rui<br>State) | ral Route Number,                                  |
|                        | To the Hospital or within 24 hours after To the Funeral Dir completely filled in                                                                                                                                                                                      |                   | 29a. Certifier  (Check only 2   Medical Examiner: On the basis of examiner)                                                                                                                                                                      |                     |                                                          |                                                            |                               |                                                      |                                                    |
|                        | thin 2,                                                                                                                                                                                                                                                               | Medical           | one) and manner stated.  29b. Signature and title of certifier                                                                                                                                                                                   |                     | 29c. Licens                                              |                                                            |                               | d. Date signed (Month                                |                                                    |
|                        | 7. <u>≥</u> 5. 8                                                                                                                                                                                                                                                      |                   | · aletin un                                                                                                                                                                                                                                      |                     |                                                          | 58137                                                      | -                             | 2/27/08                                              |                                                    |
| _                      | 611                                                                                                                                                                                                                                                                   |                   | 30. Name and address of person who completed cause of death ( Wilbur Koo 295 5+500                                                                                                                                                               | re Ave              | Print)<br>e St 30                                        | - Was                                                      | tnocke                        | e MO T                                               | 21157                                              |
|                        | Sta<br>Registi                                                                                                                                                                                                                                                        | _                 | 31. Date filed (Month, Day, Year) \$2. Registrar's S                                                                                                                                                                                             | ignature            | 1                                                        |                                                            |                               |                                                      |                                                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** PATRICIA HAMLIN February 16, 200 X 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Marp 050 a 8. Date of Birth 3-5-1 94 9 (Month 1947) Social Security Number **Funeral** Min. Hours Months Days MARYLAND 1 □ M 2 √ F 58 Director 216-52-1226 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 1 Tyes 2 No Director BALTIMORE KNOTTINGHAM MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21236 3905 LINK AVE. Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: BLACK 1 □ Never Married 2 □ Married 1 Yes 2 No þ 3 ☐ Widowed 4 X Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DEPT. OF CORRECTIONS CORRECTIONS OFFICER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANNIE R. JACKSON CHARLES E. STRICKLAND ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1627 HEALTHFIELD RD. BALTIMORE, MARYLAND 21239 ANNIE THOMAS (MOTHER) Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremat 3 Removal from State BALTIMORE, MARYLAND ARBUTÚS MEMORIAL PARK 2-25-2008 4 □ Donation 5 Other (Specify) SONATHAN D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Fund 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Oliac **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of): liom Examiner Se wentially list conditions Se prentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pt for use as tl 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 □Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No ed by the a detached i 9□Unknown 9 □ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \( \subseteq \text{No} has page 2 1X Yes 1 Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 R/Outpatient 3 DOA 21 No 1 Tyes 1 Inpatient ٩ this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A'
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 70054428 se of death (Item 23a) (Type, Print) 30. Name and address of person who completed og 0

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State

Registrar

PIPKIN

FEB 2 8 2008

32 Registrar's Signature

michael

31. Date filed (Month, Day, Year)

9000 FRANKLIN SQUARE DR. Baltimore

md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 1918 J'EFFER SON R FE13 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTERL BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Year) Months 1 □ M 2 📉 1943 Virginia Director 224-56-7666 64 March 12, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 XYes 2 No Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1716 North Washington Street 21213 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black þ 3 ☐ Widowed 4 🏻 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A is marked other 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental Hy f item 27 is marked 17. Father's Name (First, Middle, Last) Be Hester Spencer Howard Word, Sr. ဂ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3722 Coldspring La., Baltimore, MD 21215 Douglas Bailey (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of P Important: If ite 1 Burial 2 □ Cremation 3 □ Removal from State injury or Oak Hill Bapt. Ch. Cem. 2/22/08 Buckingham, VA 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility. Reid's Funeral Home any i 15317 N. James Madison Hwy., Dillwyn, VA onnes Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS 7 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PHELLMONIA Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and Due to (or as a consequence of) as the burial-Division or Vital Records, P.O. Box 68760, physiciar Physician/Medical attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No certificate has 1□ Yes Physician: 25. Was case referred to medical 26. Place of Death Check onl one Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 1 ☐ Yes 2 ER/Outpatient 3□ DOA 2 this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After Certification: Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)

H

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ALEXANDER

Registrar

DHMH 17 Rev 1/2001

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SWITE 200

ND

32. Registra Signature

110 S. FACA ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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FEB 2 8

2008

BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Thelma Jeffries ruary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner t a 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. Year Social Security Number **Funeral** Days Hours 1 □ M 2 🕱 F MD July 28, 1928 220-24-9996 79 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b. County "natural", or items 23a or 28a-f show odical Examiner must be notified at 1√Yes 2 No Baltimore Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene. 21217 USA 1600 Mount Royal Avenue Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ∏ Yes 2 ⊠ If Yes, Give Year or Dates: 2 🔯 No 1 Never Married 2 Married 1 ☐ Yes 2 🖁 No spAfrican American Maryland 21215-0036 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 77 is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 domestic homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Webb Clarence Yates 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2528 W. Lanvale Street; Baltimore, MD 21216 permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any Injury or other trau Shirley Robinson / Daughter Baltimore. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 03/01/2008 Randallstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home, P.A. 21. Signature of Funeral Service License 22. Name and Address of Facility 638 N. Gilmor Street; Baltimore, Maryland 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc, as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 3 ☐ Ectopic pregnancy 2 Fetal death Month Dav Por in the past 12 months? 1 ☐ Yes 2 X No 5 ☐ Other (specify) P.0. ed by the a 9 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Records, þ 3 Probably 4 Unknown 1 Yes 2∏ No Completed peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 2□ No certificate 1□ Division or Vital 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 2 PER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 3□ DOA al or Attending Physis after death. Il Director: After this c 2 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury Certification: 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide e Hospital o To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as same 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State

Registrar

32 Registrar's Signature

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| 8-01609<br>Idine Reuben Jo                                                                                                                                                              | nes             | Please Type or Print in Black Indelible State of Maryland / Department                                                                           |                                                                                  |                                      | ble.                                     |                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------|------------------------------------------|-----------------------------------------------|
|                                                                                                                                                                                         | f               | T-For State Registrar  1. Decedent's Name (First, Middle,Last)                                                                                   |                                                                                  | Reg.                                 |                                          | 8 06 6<br>3. Time of Death                    |
| Physiciai<br>Nedical Examin                                                                                                                                                             | -               | Aldine Reuben Jones                                                                                                                              |                                                                                  | Month D. February 25,                |                                          | 0940 hrs                                      |
|                                                                                                                                                                                         |                 | Facility Name (if not institution, give street and number)     Seafarer lane                                                                     | 4b. City, Town, or Location of Death<br>Berlin                                   | 1                                    | 4c. County of Death<br>Worcester         |                                               |
| Funeral<br>Director                                                                                                                                                                     |                 | 5. Social Security Number 213-94-6413 6. Sex 17. Age (In yrs. last birthda 42                                                                    | y) If Under 1 Year If Under 24Hr<br>Months Days Hours Min                        |                                      | MM/DD/YYYY) 9. Birth<br>Cour<br>1965 Mar | place (State or Foreign<br>htry)<br>yland     |
| any                                                                                                                                                                                     | Ī               | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L                                                                         | ocation                                                                          |                                      | 7                                        | 10d. Inside City Limits                       |
| or 28a-f show                                                                                                                                                                           | ġ               | Maryland Norcester Berlin  10e. Street and Number                                                                                                | 10f, Zip Code                                                                    | 1100                                 | Citizen of What Country                  | 1 Yes 2 XX No                                 |
| <u> </u> =                                                                                                                                                                              |                 | 58 Seafarer Lane                                                                                                                                 | 21811                                                                            | log.                                 | USA                                      | y:                                            |
| ath with the items 23a ust be noti                                                                                                                                                      | Funeral         | 1 Never Married 2 X Married Armed Forces?                                                                                                        | . Was Decedent of Hispanic Origin? ( S<br>If Yes, specify Cuban, Mexican, Puerto |                                      | 14. Race - America<br>White, etc.        | an Indian, Black,                             |
|                                                                                                                                                                                         | by Fu           | 1 Yes 2 No 3 Widowed 4 Divorced or Dates:                                                                                                        | Yes 2 X No specify:                                                              |                                      | Specify: White                           |                                               |
| 136<br>Ihin 72 hours afte<br>ie.<br>Ihan "natural",<br>edical Examiner                                                                                                                  | -<br>  <u>g</u> | Elementary/Secondary (0-12) College (1-4 or 5+)                                                                                                  | edent's Usual Occupation (Give kind of<br>ng most of working life. DO NOT use re |                                      | 6b. Kind of Business/In                  | dustry                                        |
| 0036<br>within 7;<br>iene.<br>Per than                                                                                                                                                  | Completed       |                                                                                                                                                  | ecutive Chef                                                                     |                                      | Restaurant                               |                                               |
| 21215-0036 Build be filed within 7 Mental Hygiene, marked other than c event, the Medica                                                                                                | Be C            | 17. Father's Name (First, Middle, Last)  James Jones, Jr.                                                                                        | 18.Mother's Nam                                                                  | e (First, Middle, Mai<br>Andrews     | iden Surname)                            |                                               |
| O & B is it                                                                                                                                                                             | 티               | 19a. Informant's Name/Relationship (Type, Print ) 19b. M                                                                                         | ailing Address (Street and Number or<br>Seafarer Lane Berline                    | Rural Route Number                   |                                          | Zip Code)                                     |
| Fe, M<br>1 and 2<br>Health<br>if item 2                                                                                                                                                 | ŀ               | 20a. Method of Disposition 20b. Place of Di                                                                                                      | sposition (Name of cemetery, or other place)                                     |                                      | 20c. Location - City or T                | own, State                                    |
| Baltimore,<br>permit. Pages 1 ar<br>Department of Hea<br>Important: If itee                                                                                                             |                 | 4 Donation 5 Other Specify: Morel and                                                                                                            | Memorial Park 2/                                                                 |                                      | Baltimore Mar                            | yland                                         |
| Balt<br>permit.<br>Depart<br>Impor                                                                                                                                                      |                 | 21. Signature of Funeral Service License                                                                                                         | <sup>22</sup> Name and Addres Rolf Rold Inc.<br>5305 Harford Rold Ba             | ltimore Mar                          | ryland 21214                             |                                               |
| Physician<br>/Medical                                                                                                                                                                   | 1               | 23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line. Narcotic (Oxycodone | nter the mode of dying, such as cardiac<br>and Methadone) and E                  | or respiratory arrest<br>hanol Intox | , shock, or heart<br>Kication            | Approximate Interval<br>Between Onset and     |
| kaminer                                                                                                                                                                                 |                 | Immediate Cause (Final disease or condition resulting in death)  a Cut licating ly a tonsi                                                       |                                                                                  |                                      |                                          | Death                                         |
|                                                                                                                                                                                         | اة.<br>ا        | Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):                                                  |                                                                                  |                                      |                                          |                                               |
|                                                                                                                                                                                         |                 | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):            |                                                                                  |                                      |                                          |                                               |
| and and                                                                                                                                                                                 | <u>ب</u><br>ا   | d                                                                                                                                                | Police new research                                                              | A POLYMEN AND                        |                                          |                                               |
| ਹ ਜ਼ਿਜ਼ ਹੈ                                                                                                                                                                              | led<br>ed       | UNPENDED X AMENDED 23a, Pt 11, 27, IF FEMALE: 23c. If yes, outcome of pregnancy                                                                  | 28a-1, per ME g877 3/                                                            | 10/00 amh                            | 23d. Date of delivery                    |                                               |
| Box 68760, c death certificate be ex the attending physician defor use as the burial                                                                                                    |                 | 23b. Was decedent pregnant in the past 12 months?                                                                                                | Fetal death 3 Ectopic pregr                                                      | nancy                                |                                          | ay Year                                       |
| Box<br>ne death<br>the atte                                                                                                                                                             | hysic           | 1 Yes 2 No 9 Unknown g Unknown                                                                                                                   | Other (Specify)                                                                  |                                      |                                          |                                               |
| P,C                                                                                                                                                                                     | ≲               | Part II. Other significant conditions contributing to death but not resulting in Muscular Dystrophy                                              | the underlying cause given in Part I.                                            | 1 Yes                                | acco use contribute to to 2 No 3 Proba   | ne cause of death?<br>ably 4 ✔ Unknown        |
| Division of Vital Records, Is a sterding Physician: The law requires rs after death.  In Director: After this certificate has been signed in by the finneral director, page 2 should be | Completed       |                                                                                                                                                  |                                                                                  | 24a. Was an<br>autopsy               | prior to co                              | opsy findings available ompletion of cause of |
| tal Reco                                                                                                                                                                                | <u>E</u> 0      |                                                                                                                                                  |                                                                                  | perform<br>1 ✓ Yes 2                 |                                          | 2 No                                          |
| Vital hysician:                                                                                                                                                                         | o Be            | 25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpa                                                       | 26.Place of Death (Check<br>atient 3 DOA Other, Nurs                             |                                      | esidence 6 🗸 Other:                      | Scene                                         |
| n of ding Ph                                                                                                                                                                            | ä               | 27. Manner of Death 28a. Date of Injury (Month, Dey, Year) 28b. Tim                                                                              | e of Injury 28c. Injury at Work?                                                 | 28d. Describe ho                     | w injury occurred                        |                                               |
| viSiO<br>or Atten<br>ter deatl<br>irrector:<br>n by the                                                                                                                                 | Certification:  | Pending Investigation  Suicide 6 XX Could not be Pending Investigation 28e. Place of Injury - At home, farm,                                     | 7.50 all                                                                         |                                      | eet and Number or Rur                    |                                               |
| Division To the Hospital or Attends within 24 hours after death. To the Funeral Director: A Completely filled in by the fi                                                              | 2<br>  G        | 4 Homicide determined (Specify) HOUSE                                                                                                            |                                                                                  | Berlin, M                            |                                          |                                               |
| thin 24 of the Fu                                                                                                                                                                       | Medical         | (Check only one)  2 Medical Examiner: On the basis of examination and/or inveand manner stated.                                                  |                                                                                  |                                      |                                          |                                               |
| F 2 F 8                                                                                                                                                                                 | <b>≗</b>        | 29b. Signature and title of certifier                                                                                                            | 29c. License number                                                              |                                      | 29d. Date signed (Mon                    |                                               |
|                                                                                                                                                                                         | -               | 30. Name and address of person who completed cause of death (Item 23a)                                                                           | O.C.M.E.                                                                         |                                      | February 26, 200                         | · · · · · · · · · · · · · · · · · · ·         |
|                                                                                                                                                                                         | -               | Ana Rubio MD. Assistant Medical Examiner 111 Per                                                                                                 | nn Street, Baltimore, MD 2120                                                    | )1                                   |                                          |                                               |
| Sta<br>Registr                                                                                                                                                                          |                 | 31. Date filed (Month, Day, Year) 32/Registrar's Signature                                                                                       | and I                                                                            |                                      |                                          |                                               |

Registrar DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per fh 9877 3-13-08 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 26, Carolyn G. Kloetzli 2008 8:10 A<sup>M</sup> 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore Stella Maris Timonium If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 27,1921 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Months Days 1 □ M 2 X F Maryland 217-16-1792 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Maryland Baltimore Timonium 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 2525 Pot Spring Road S-503 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Garten Caroline Neukomm 19a. Informant's Name/Relationship (Type. Print)
Walter
William Kloetzli, Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Pot Spring Road S-503 Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 102/27/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Yrs Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9∏Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

FEBRUARY P.O. I Records, KLOETZLI AROLYN

The law requires that the death certificate be executed signed by the at t be detached for page 2 has Division or Vital or Attending Physician: director, this funeral After To the Hospital or Attendir within 24 hours after death,

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show adval Examiner must be notified at

other traumatic event,

permit, Pages 1 and Department of Healt Important: If item 2 any Injury or other 1

Physician

Examiner

burial-tran

use

Por

attending physician as the

/Medical

Director

Completed by Funeral

Be

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Completed by Physician/Medical Examiner

Be

Medical Certification: To

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

8:10

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

J. Mora,

29c. License number 132,22 29d. Date signed (Month, Day, Year) 2008

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 ROBERT MOSS, M.D.

FEB28 2008



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH G87/ 3/19/08 JH Certificate of Death | For amend #8 Per FH G877 3/197 | Fixed Registrar Amend 19a, perFH, g877 3/5/08 TT |
1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February **Physician** 25,2008 MARVIN OLA KASE 10:20 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville Charlestown Care Center 8. Date of Birth JUNA, Day, Year) Aug. 26,1929 North Carolina If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M M 2 □ F 78 213-26-5873 Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No N/A Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21229 608 Orpington Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify. Specify: White <u></u> 3 Nidowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any Injury or other traumatic event, the Medieral once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government IRS Investigator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Co1e Della John Kase 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8335 Fairwood Drive, Pasadena, Maryland 21122 (Son) Michael M. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Lakeview Mem. Park 02-29-08 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses According to the second Address of Facility (Cully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 1hr Approximate Interval Between Onset and Death ent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final disease or condition resulting in death) 90(86 **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by ate has been signe page 2 should be 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No certificate Yes Physician: 25. Was case referred to medical examiner? funeral director. 26 Place of Death (Check only one) Be Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred the Hospital or Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) onel and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif UND 30. Name and addrest of person who completed cause of death (Item 23a) (Type, Print) (910

DHMH 17 Rev 1/2001

Registrar

9,21,5

Year)

31. Date filed (Month, Day,

March

32. Registrar's Signature

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ERIC KOMITZSKY FEBRUARY 2008 1:49 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F 214-62-2941 56 07/26/1951 Director MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits f show 10b. County ral", or items 23a or 28a-f shov Examiner must be notifled at 1 ☐ Yes 2 X No MD BALTIMORE Director BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6711 BERKELEY AVE., APT. C-1 21209 USA · death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. filed within 72 hours after Hygiene. other than "natural", or ite 1 TYYes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🕅 No Specify Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: if item 27 is marked other this any injury or other traumatic event, the once. PURCHASER CITY OF BALTIMORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KOMITZSKY BENJAMIN MADELEINE ZESKIND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARI MOYE / SISTER 3712 OLD MILFORD MILL ROAD, BALTIMORE, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CONG. 02/26/2008 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Sign are Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Danciecho mouths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and A requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No certificate has 1 Yes 25. Was case referred to medical examiner? 26 Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident сотріете filled in by the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 🏸 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 24,2008 00051926 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Baltunge Med 21204 HERONM, Gardon 6565 N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 8 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Virginia Lynch 8:00 AMM February 15, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 27 Glyndon Drive #Al Reisterstown Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F Director 090-01-1108 91 Yrs 1916 New Jersey Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itama 23a or 28a-f ahow the Medical Examinar must be notified at Director 1 ☐ Yes 2√ No Baltimore Reisterstown 10e. Street and Number 10f. Zin Code 10g. Citizen of Whal Country? USA 27 Glyndon Drive #Al 21136 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedenl's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk f Heelth and Mental Hygiene. Itam 27 is marked other than " other traumatic avant, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: If Itam 27 is markad oth any injury or other traumatic avant <u>once.</u> James Albert White Ida Josephine Osback 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lauren J. Lynch/daughter 27 Glyndon Drive #Al Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Ser Ronal of State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Enler the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastati **Physician** Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine led by the ettending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cete hes been sig , page 2 should b 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpalient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☑ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide efter To the Hospital or within 24 hours e To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nd address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

.O. Box 68760,

Division of Vital Records, P.

|                                                                                                                         |                                                                 |                      | 1 - For<br>State<br>Registrar                                                                                                                                                   | State of Maryla                                                                               | and / Depa                                 | artment of H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | lealth and N<br>Death                                |                                         | ene 0 0 8                              | 06171                                                   |
|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------|----------------------------------------|---------------------------------------------------------|
|                                                                                                                         | hysici<br>/Medio                                                |                      | 1. Decedent's Name (First, Middle, La.  Roy Benjamin I                                                                                                                          |                                                                                               |                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                      | 2. Date of Death Month                  | Day Year 22                            | 3. Time of Death                                        |
| E                                                                                                                       | xamin                                                           | ner                  | 4a. Facility Name (If not institution, givi<br>3400 Bero Road                                                                                                                   | e street and number)                                                                          |                                            | 4b. City, Town, or<br>Lansdown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Location of Death                                    |                                         | 4c. County of De<br>Baltim             | ath<br>Ore                                              |
|                                                                                                                         | neral<br>ector                                                  |                      |                                                                                                                                                                                 | ex 7. Age <i>Un.y</i> .                                                                       | rs. last birthday)<br>Yrs.                 | If Under 1 Year<br>Months Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | If Under 24 Hrs.<br>Hours Min.                       | 8. Date of Birth                        | 9ar) 1944 9. Bi                        | rthplace (State or Foreign<br>North Caroli              |
| Maryland                                                                                                                | lied at                                                         | tor                  | Usual Residence of Decedent  10a State Baltim                                                                                                                                   | ore La                                                                                        | City, Town or Lo                           | cation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                      |                                         |                                        | 10d. Inside City Limits                                 |
| with the                                                                                                                | It be not                                                       | Funeral Director     | 3400 Bero Road                                                                                                                                                                  |                                                                                               | ···                                        | 10f. Zip Code<br>21227                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                      | 10g                                     | . Citizen of What C                    | Country?                                                |
| 72 hours after deeth with the Maryland                                                                                  | other treumatic event, the Medical Examiner must be notified at | ٥                    | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced                                                                                                              | 12. Was Decedent Ever in<br>Armed Forces?<br>1 ☐ Yes 2 ② No<br>If Yes, Give<br>Year or Dates: |                                            | Was Decedent of Hi<br>f Yes, specify Cuba                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | spanic Origin? (Sp<br>n, Mexican, Puerto<br>Specify: | pecify Yes or No-<br>Rican, etc.)       | 14. Race - Am<br>Black, Wh<br>Specify: |                                                         |
| nd 2 should be filed within 72 hours att                                                                                | the Medical                                                     | Completed            | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)                                                                                                   | de completed)  College (1-4or 5+)                                                             | (Give                                      | dent's Usual Occupa<br>kind of work done of<br>DO NOT use retired<br>ine Mecha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | furing most of work<br>)                             | sing 16                                 | b. Kind of Business                    |                                                         |
| ould be filed<br>Mental Hygid                                                                                           | tic event,                                                      | o Be C               | 17. Father's Name (First, Middle, Last) Roy Lee, Sr.                                                                                                                            |                                                                                               |                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                      | e (First, Middle, Ma<br>Ide White       | iden Surname)                          |                                                         |
| 1 and 2 should<br>Heelth and Men                                                                                        | r treuma                                                        |                      | 19a. Informant's Name/Relationship (18 Roy B. Lee, IV                                                                                                                           | Гуре, Print)                                                                                  | 19b. Mailin                                | g Address (Street a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Rd. Bal                                              | al Route Number, C<br>timore, M         | ity or Town, State, D. 2122            |                                                         |
| permit. Pages 1 at Department of Hee                                                                                    | ury or oth                                                      |                      | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify                                                                                         | Removal from State                                                                            | Place of Dispo<br>cemetery.cre<br>Meadowri | sition (Name of<br>natory or other place<br>dge Memor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                      | Date 20<br>02-27-08                     | c. Location - City o<br>Lansde         |                                                         |
| permit.<br>Depart                                                                                                       | eny in                                                          |                      | 21. Signature of Funeral Service Licen                                                                                                                                          | 500 _                                                                                         | 22                                         | Ambrose 1<br>2719 Hamn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Tufferal H<br>nonds Fer                              | ome of Lary Rd. I                       | nsdowne<br>ansdowne                    | , MD. 21227                                             |
| Exam                                                                                                                    | for use as the burial-transit                                   | edical Examiner      | resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a cons  Due to (or as a cons  C. Due to (or as a cons  d.                    | equence of):                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | n Ce 1                                               |                                         |                                        | Tyen                                                    |
| death certif                                                                                                            | nached for use as th                                            | Physician/Medi       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                                                                         | 23c. If yes, outcome of preg<br>1 Live birth 2 Fe<br>4 Pregnant at time of<br>9 Unknown       | etal death 3                               | Ectopic pregnancy Other (specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                      |                                         | 23d. Date of de<br>Month               | olivery<br>Day Year                                     |
| es th                                                                                                                   | peq                                                             | þ                    | Part II. Dther significant conditions co                                                                                                                                        | ontributing to death but not re                                                               | esulting in the un                         | derlying cause give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | n in Part I.                                         |                                         | 1                                      | to the cause of death?                                  |
| The de                                                                                                                  | r, page 2 should                                                | Completed            |                                                                                                                                                                                 |                                                                                               |                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                      | 24a. Was an autopsy performer           | prior to death?                        | utopsy findings available completion of cause of s 2 No |
| To the Hospital or Attending Physician:<br>within 24 hours efter death.<br>To the Funeral Director: After this certific | · =                                                             | Certification: To Be | 27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be                                                                                      | 28a. Date of Injury<br>(Month, Day Year)                                                      |                                            | 28c. Injury<br>Work<br>M 1 TY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | r: 4 Nursing Ho                                      | me 5 Residence 28d. Describe how        | njury occurred                         |                                                         |
| pital or Attending Phy<br>urs efter death.<br>eral Director; After this                                                 | illed in by                                                     |                      | 4 Homicide determined                                                                                                                                                           | building, etc. (Spec                                                                          | cify)                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                      | 28f. Location (Stree<br>City or Town, S | itate)                                 |                                                         |
| To the Hospital<br>within 24 hours e<br>To the Funeral (                                                                | completely t                                                    | Medical              | 29a. Certifier (Check only one)  1 □ Certifying Phyone 2 □ Medical Exam  29b. Signature and title of Certifier                                                                  | rsician: To the best of my kiner: On the basis of examinand manner stated.                    | nowledge, death<br>nation and/or inv       | occurred at the time<br>estigation, in my op                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | inion, death occurr                                  | ed at the time, date                    | e(s) and manner a<br>and place, and du | e to the cause(s)                                       |
| \h                                                                                                                      |                                                                 |                      | 30. Name and address of person who c                                                                                                                                            | ompleted cause of death (It                                                                   | Pm 23a) (Type. I                           | Print) 25                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 274                                                  |                                         |                                        | lo 100)                                                 |
| 1.9                                                                                                                     | Stat                                                            |                      | 7 ( LAA b)                                                                                                                                                                      | n1 K, 77                                                                                      |                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Mesi                                                 | u los                                   | of the                                 | Ko Mum                                                  |
| Re                                                                                                                      | egistra                                                         |                      | FEB 2 8 201                                                                                                                                                                     | 32 Hegistrar's Sign                                                                           | St Again                                   | and the same of th |                                                      |                                         |                                        |                                                         |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 25 12:17P <sup>™</sup> 2008 LEVIN RALPH 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON 8. Date of Birth (Month, Day. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 🕍 M 2 🗆 F Days Hours Min. 85 Yrs. 12/29/1922 IL 213-14-3852 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 □ Yes 2 □ No PIKESVILLE MD BALTIMORE 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21208 USA 7 POMONA WEST, APT.#6 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No WW I I If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VENDING 12 OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FINE FRANK LEVIN BEATRICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7 POMONA WEST, APT. #6, PIKESVILLE, MD 21208 MAE LEVIN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □Cremation 3 ☐ Removal from State 02/27/2008 BALTIMORE, MD BETH TFILOH CONG. 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility Funeral Service Licens SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complication and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) proved abdominal antic ancorysm Due o (or as a consequence of): Vascular disease ears Theosoloopic Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2X No 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

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attending physician for use as the buria

certificate has be irector, page 2 s

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Director:

within 24 hours aft

To the Funeral DI

completely filled in

Hospital or Attending

Physician/Medical

Completed by

Be

Certification: To

requires that the death certificate be executed

Box 68760,

P.O.

Division or Vital Records,

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

ath and Mental Hygir 27 Is marked other I r traumatic event, th

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permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other

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Funeral Director

Be Completed by

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with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

23b. Was decedent pregnant

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

3 Suicide 4 ☐ Homicide

6 Could not be

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOSPICO 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

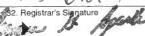
D 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AHON J. CHANUS W) GOU N. Changes St. Tow SON in ZNOY

29d. Date signed (Month, Day, Year) February 26 2008

State Registrar 31. Date filed (Month, Day, Year)

2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 0200 AM Month **Physician** ouse 24 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Min. Hours 1 □ M 2 🖾 F 76 30, 215-28-4036 May Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐Yes 2√☐No Director MD Carroll Hampstead 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 2310 Susanann Drive 21074 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: white 3X Widowed 4 ☐ Divorced Year or Dates 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) unk unk (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) is 1 and 2 should be filed within the Halth and Mental Hygiene. 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Edward Jacobs Thelma Anna Keithley Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Meister III/son P.O. Box 596 Hampstead, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Sigurture of Funeral Service I censee Ronald & Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 . Enter the disease or complications that caused the k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediat ause (Final Physician Acinetobacter 3 week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of train, leading to in readicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and burial-tra Due to (or as a consequence of): Box 68760, attending physician for use as the buria certificate be Physician/Medical as the IF FEMALE: nse yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þe 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy this certificate 2X No 1 TYes 2□ No 1∐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury 1 X Natural within 24 hours after upour...

To the Funeral Director: After 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Registrar

State

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

4

FEB28

Internal Medicina Resident

32. Remetar's Signature

Greenc

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

29c. License number

29d. Date signed (Month, Day, Year)

Feb 24.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $\gamma$   $\cap$ Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROBERT CHARLES MAVIS FEBRUARY 25, 11:05 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE HOSPITAL CENTER HARFORD FALLSTON Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Months Davs Hours Min Director 072-18-4174 3/13/1924 NEW YORK Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD HARFORD **JOPPA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 526 A RIVIERA DRIVE Funeral 21085 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. tX Yes 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify ģ Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ADHESIVES MANUFACTURE 4\_YEARS CHEMIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ ROBERT LUKE MAVIS FRANCES MARY MERINEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN RICH/BROTHER-IN-LAW 334 LOCUST THORN CT. MILLERSVILLE, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 timor jo 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 2/27/2008 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Intravascular Congulapathy Immediate Cause (Final Disseminated **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Hypertension 24a. Was an perform Vital 2 1 No or Attending Physician; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 TAccident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) strar's Signature State 8 2008

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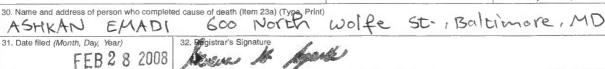
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State Registrar 31. Date filed (Month, Day, Year) FEB28

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32. gistrar's Signature 2008

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|                                                                                                                                                                                                                              | <u>.</u>                                        |                | 1. Decedent's Name (First, Middle, La                                                                                                                      | ast)                                                                                    |                              |                                                                                                                   |                                            | 2. Date of De                        | eath (                         | 008                                         | 3. Time of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                              | ıysici:<br>Medic                                |                | SHEILA                                                                                                                                                     | Vic fhaul                                                                               |                              |                                                                                                                   |                                            | Month<br>O2                          | Day Z                          | Year<br>OS                                  | 424 AM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                              | camin                                           |                | 4a. Facility Name (If not institution, gi                                                                                                                  |                                                                                         |                              |                                                                                                                   | or Location of Death                       | 1                                    | 4c. Cou                        | nty of Death                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                              | n so ja                                         |                | UNIVERSITY OF  5. Social Security Number 6.                                                                                                                | MARYLAN<br>Sex 7. Aq                                                                    | e (In yrs. last birthd       | BALTIMO Y                                                                                                         | RE,<br>If Under 24 Hrs.                    | 8. Date of Bi                        | rth                            | O Diath                                     | olean (Ctata - Familia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                              | ector                                           |                |                                                                                                                                                            | 1 M 2 M F                                                                               | 49 Yrs                       | Months Dave                                                                                                       |                                            | (Month, Da                           | ay, Yea <i>r)</i><br>6–1958    | Cour                                        | place (State or Foreign<br>ntry)  MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| land<br>ow                                                                                                                                                                                                                   | #                                               |                | 10a. State 10b. County                                                                                                                                     |                                                                                         | 10c. City, Town or           | Location                                                                                                          |                                            |                                      |                                | 1                                           | 10d. Inside City Limits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Mary<br>I-f sh                                                                                                                                                                                                               | fied                                            | tor            | MD                                                                                                                                                         | N/A                                                                                     | Balt                         | imore                                                                                                             |                                            |                                      |                                |                                             | XXYes 2 □ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| death with the Maryland<br>ms 23a or 28a-f show                                                                                                                                                                              | o not                                           | Director       | 10e. Street and Number                                                                                                                                     |                                                                                         | <u> </u>                     | 10f. Zip Code                                                                                                     |                                            |                                      | 10g. Citizen                   | of What Cour                                | ntry?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| th wil                                                                                                                                                                                                                       | ust b                                           | ral [          | 3462 Park Heig                                                                                                                                             | ghts Aven                                                                               | ue                           | 21215                                                                                                             |                                            |                                      | U S                            | S A                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| hours after des                                                                                                                                                                                                              | event, the Medical Examiner must be notified at | by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed ◆□ vivorced                                                                                 | 12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: |                              | 13. Was Decedent of Hispanic Origin? (Spec<br>If Yes, specify Cuban, Mexican, Puerto R<br>1 ☐ Yes 2 X No Specify: |                                            | pecify Yes or No<br>o Rican, etc.)   | 0- 14. F<br>E<br>Spe           | Race - Americ<br>Black, White,<br>cify: Bla | etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 72 ho                                                                                                                                                                                                                        | lical                                           | sted           | 15. Decedent's E<br>(Specify only highest gi                                                                                                               | ducation                                                                                | 16a. De                      | cedent's Usual Occu                                                                                               | pation                                     | king                                 | 16b. Kind of                   | Business/In                                 | dustry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| within 72 hours aftene.                                                                                                                                                                                                      | Mec                                             | Completed      | Elementary/Secondary (0-12)                                                                                                                                | College (1-4or 5                                                                        | i+) (life                    | ive kind of work done<br>e. DO NOT use retire                                                                     | ed)                                        | Killy                                | Bus C                          |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| filed w<br>Hygien                                                                                                                                                                                                            | t, th                                           | ပိ             | 10th grade                                                                                                                                                 |                                                                                         | /A                           | Clerical                                                                                                          |                                            | - /F' - 4 A A' - 1 H                 |                                |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| lallo<br>lid be filk<br>fental Hy<br>rked oth                                                                                                                                                                                | evel                                            | Be             | Daniel Stavis                                                                                                                                              | <i>(</i> )                                                                              |                              |                                                                                                                   | 18. Mother's Nan                           |                                      | e, Maiden Surr                 | iame)                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| d d la                                                                                                                                                                                                                       | matic                                           | ျှ             | 19a. Informant's Name/Relationship                                                                                                                         | (Type, Print)                                                                           | 19b. M                       | ailing Address (Stree                                                                                             |                                            |                                      | ner. City or Toy               | vn State Zir                                | Code)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| In 2 Pd 2                                                                                                                                                                                                                    |                                                 | 3              |                                                                                                                                                            | naul-Daug                                                                               |                              |                                                                                                                   |                                            |                                      |                                | alto,                                       | ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| r a a e                                                                                                                                                                                                                      | othe                                            | -              | 20a. Method of Disposition                                                                                                                                 | _                                                                                       |                              | sposition (Name of crematory or other pla                                                                         |                                            | Date                                 |                                | n - City or To                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| permit. Pages Department of H                                                                                                                                                                                                | any Injury or othe                              | 1              | 1 TBurial 2 □ Cremation 3 [<br>4 □ Donation 5 □ Other (Spec                                                                                                | ☐Removal from State                                                                     | 1                            | s Memoria                                                                                                         |                                            | -2008                                | Arbut                          | us, N                                       | 1D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| rmit.                                                                                                                                                                                                                        | any Inju                                        |                | 21. Signature of Functor Service Lice                                                                                                                      | nsee                                                                                    |                              | 22. Name and Addre                                                                                                | ess of Facility                            | March I                              | r/H Ea                         | st                                          | 2120                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 1 85E                                                                                                                                                                                                                        | o a                                             | 1 1            | grette                                                                                                                                                     | K' Jones                                                                                |                              |                                                                                                                   | Ol E. No                                   | orth Av                              | venue                          | Balt                                        | co, MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                              | 2                                               |                | 23a. Part1. Enter the disease, or conshock, or heart failure. List only                                                                                    | nplications that caused<br>one cause on each lir                                        | the death. Do not<br>ne.     | enter the mode of dy                                                                                              | ing, such as cardiad                       | or respiratory a                     | arrest,                        |                                             | Approximate<br>Interval Between<br>Onset and Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Physic<br>/Med                                                                                                                                                                                                               | lical                                           |                | Immediate Cause (Final disease or condition resulting in death)                                                                                            |                                                                                         | AIN DE a consequence of):    | ATH                                                                                                               |                                            |                                      |                                | -                                           | 10 hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Exami                                                                                                                                                                                                                        | 2.13                                            |                | Sequentially list conditions.                                                                                                                              |                                                                                         | AUMATIC                      | BRAIN :                                                                                                           | DNOURY                                     |                                      |                                |                                             | E.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| pə                                                                                                                                                                                                                           | sit                                             | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 0                                                                                       | a consequence of):           | Ch                                                                                                                | uck                                        | 1                                    | 1/                             | 30                                          | The same of the sa |
| xecut                                                                                                                                                                                                                        | s the burial-transit                            | хап            | that initiated events<br>resulting in death) Last                                                                                                          | 0.                                                                                      | a consequence of):           | ~ 3m                                                                                                              | UCK                                        | 1                                    |                                | of Helician                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ficate be ex                                                                                                                                                                                                                 | buris                                           |                |                                                                                                                                                            | · d                                                                                     |                              |                                                                                                                   |                                            | W- N                                 |                                | 204                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| tificate<br>g phy                                                                                                                                                                                                            | res l                                           | edical         |                                                                                                                                                            |                                                                                         |                              |                                                                                                                   | -                                          |                                      | Paga                           |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and | r use                                           | Physician/M    | IF FEMALE:<br>23b. Was decedent pregnant                                                                                                                   | 23c. If yes, outcome                                                                    |                              | 3 □Ectopic pregnanc                                                                                               | 71/                                        |                                      | 23d.                           | Date of delive                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| e deal                                                                                                                                                                                                                       | ed for                                          | sicis          | in the past 12 months?<br>1 ☐ Yes 2 ☑ No                                                                                                                   | 4□Pregnant at<br>9□Unknown                                                              |                              | 5 ☐ Other (specify) _                                                                                             |                                            |                                      | ERTHIN                         | Month                                       | Day Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| nat the                                                                                                                                                                                                                      | etach                                           | Ph             | 9 Unknown                                                                                                                                                  |                                                                                         | of an edition of the edition | and the second                                                                                                    | . 5 . 1                                    | On Bid                               |                                |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ires #                                                                                                                                                                                                                       | pe d                                            | 2              | Part II. Other significant conditions                                                                                                                      | contributing to death bi                                                                | ut not resulting in the      | e underlying cause gr                                                                                             | ven in Part I.                             |                                      |                                | _                                           | he cause of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| w requires t                                                                                                                                                                                                                 | hould                                           | Completed      |                                                                                                                                                            |                                                                                         |                              |                                                                                                                   |                                            |                                      |                                |                                             | Dably 4 Olikhown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| has I                                                                                                                                                                                                                        | ge 2 s                                          | d l            |                                                                                                                                                            |                                                                                         |                              |                                                                                                                   |                                            | 24a. Was                             |                                | prior to co                                 | psy findings available<br>impletion of cause of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| n: Th                                                                                                                                                                                                                        | or, pa                                          |                | 25. Was case referred to medical                                                                                                                           |                                                                                         |                              | <del></del>                                                                                                       |                                            | 1□ Yes                               | 2 No                           | 1 Yes                                       | 2 <b>1</b> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| soerti                                                                                                                                                                                                                       | lirecto                                         | o Be           | examiner?                                                                                                                                                  | Hospital: 1 The patie                                                                   | nt 2 ☐ ER/Outpat             | tient 3D DOA Otl                                                                                                  | 26. Place of Dea                           | th <i>(Check only</i><br>ome 5□ Res  |                                | D4h ++ /G                                   | 6.3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| a Physical                                                                                                                                                                                                                   | erald                                           | ا<br>ا         | 27. Manner of Death                                                                                                                                        | 28a. Date of Injur                                                                      | ry 28b. Time                 | e of 28c. Inju                                                                                                    |                                            | 28d. Describe                        |                                |                                             | y)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| ath.                                                                                                                                                                                                                         | ne fun                                          | Certification: | 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation                                                                                                         | (Month, Day                                                                             |                              |                                                                                                                   | Yes 2 140                                  | Pedes                                | trian                          | Ptru c                                      | K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| r Atte                                                                                                                                                                                                                       | by th                                           | tific          | 3 Suicide 6 Could not be 4 Homicide determined                                                                                                             | e 28e. Place of inju                                                                    |                              | street, factory, office                                                                                           |                                            | 28f. Location (                      | Street and Nu                  | mber or Rura                                | al Route Number,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| ital o<br>irs aft                                                                                                                                                                                                            | led ir                                          | Če             |                                                                                                                                                            | STRE                                                                                    | ET                           |                                                                                                                   |                                            | 3600 R                               | EISTERS                        | TOWN RO                                     | AD, BALTIMORE, MI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Hosp<br>24 hou<br>Fune                                                                                                                                                                                                       | tely fi                                         | edical         | 29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa                                                                                               | nysician: To the best ominer: On the basis of                                           | examination and/or           | eath occurred at the t<br>r investigation, in my                                                                  | ime, date and place<br>opinion, death occu | , and due to the<br>rred at the time | cause(s) and<br>date and place | manner as s<br>ce, and due to               | tated.<br>o the cause(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| o the<br>ithin 2                                                                                                                                                                                                             | эшріе                                           | Med            | 29b. Signature and title of certifier                                                                                                                      | and manner sta                                                                          | ited.                        | 29c. Licens                                                                                                       | se number                                  |                                      | 29d. Date sig                  | ned (Month.                                 | Dav. Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ŕšř                                                                                                                                                                                                                          | ರ                                               |                |                                                                                                                                                            |                                                                                         |                              | i                                                                                                                 | 8277                                       |                                      | _                              | 2 2                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| $\prec$                                                                                                                                                                                                                      |                                                 | -              | 30. Name and address of person who                                                                                                                         | completed cause of de                                                                   | eath (Item 23a) (Tyr         | ne. Print)                                                                                                        | 10 45                                      |                                      |                                |                                             | , 50                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| le '                                                                                                                                                                                                                         |                                                 |                | MAYUR                                                                                                                                                      | NAPLAY AN                                                                               | *22                          |                                                                                                                   | GREENE                                     | STREET                               |                                |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                              | Stat                                            | _              | 31. Date filed (Month, Day, Year)                                                                                                                          | 32. Registra                                                                            | ar's Signature               |                                                                                                                   |                                            |                                      |                                |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                              | gistra                                          |                | FEB 2 8 200                                                                                                                                                | 8 Alaskan                                                                               | De Apre                      | West of the second                                                                                                |                                            |                                      |                                |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| HMH 17 R                                                                                                                                                                                                                     | ev 1/20                                         | 01             |                                                                                                                                                            |                                                                                         | 4                            |                                                                                                                   |                                            |                                      |                                |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #8 perFH G879 5/9/08 Tertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** <u>12:5</u>5a<sup>M</sup> Raymond Muldrow February 25, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Riverdale, Maryland Prince
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
| Months | Days | Hours | Min. | (Month, Day, Year) | 1953 Crescent Cities Nursing Home Prince George's Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XXM 2 F Yrs. Director South Carolina 579-74-4454 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturar; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No MD Prince George's Capital Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6512 Ronald Road 20743 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes ŽIXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Special Police Metro 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be J.P. Muldrow Dorothy Mae Davis မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Muldrow/ Wife 6512 Ronald Road #201, Capital Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Resurrection Cem. 3-1-2008 Clinton, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Marshall's Funeral Home of MD Donald Gray 4308 Suitland Road, Suitland, MD 20746 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) startric **Physician** Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease of Ir jury) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be execute Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as been signed by the attending I should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2510 After this certificate 1 or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 1 Tes 254 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation (Month, Day Year) Injury 1 □ Yes 2 □ No 2 ☐ Accident within 24 hours after death

To the Funeral Director: A 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary B. Wilks 31. Date filed (Month, Day, Year) 6095 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical Facility Name (If not institution, give street and number 4b. City Jown, or Location of Death Examiner OWG Ulas Holac OVICH Naus If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year\_ 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days **™** 2 □ F Director 169-01-4650 Aug 14 1914 PΑ Usual Residence of Decedent реглії. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Columbia 1 □Yes 2√□No Director MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6336 Cedar Lane 21044 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 WWII Specify: white 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) construction carpentry contractor 12 18. Mcther's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jovan Macut Milka Evosevic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Kathleen Zivkovich (niece) 5454 Crow Flock Ct., Columba, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State Grandview Cemetery 3-1-08 North Versailles, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License Dauge Haight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) QUC CV **Physician** /Medical Due to (or as a concequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 'es 2 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 ER/Outpatient 3 DOA P 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide f 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19210W

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MARKET

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 26 2008 **Physician** RANK A. MASSONI 12:50 p <sup>M</sup> February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 4612 Elsrode Ave. Baltimore 8. Date of Birth (Month, Day, Ye OCt. 11, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year) 1922 Maryland 1 M 2 □ F Months 85 216-12-9621 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. inside City Limits 28a-f show Examiner must be notified at 1 ¥ Yes 2 □ No Director Baltimore MD n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code USA 21214 4612 Elsrode Avenue or items 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Allied Folders: All Mayes 2 □ No '43 - '46 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White ğ Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 Is marked other than Meter Reader BGE/Utility 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adeline Massoni Orazio ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4612 Elsrode Ave., Baltimore, MD 21214 Josephine P. Massoni-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or otl 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/29/08 Overlea, MD Gardens of Faith 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lio William G. Dau 22. Name and Address of Facility Leonard J. Ruck. Inc. Funeral Home 5305 Harford Rd., Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 20 years mphyseme disease or condition resulting in death) /Medical Due to (or we a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Ent. Linderlyin Cause (Disease or injury Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed aftending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2∏ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 1 ☐ Yes 2 No Be ( 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To 28a. Date of Injury 27. Manner eath 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 (Month, Day Year) 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral D I 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

Francis Wiegman
31. Date filed (Month, Day, Year)
FEB 2 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

1205

32. Registrar's Signature

29c. License number

orkild

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death (First, Middle, Last) Day **Physician** Year FOD 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Baltimore Randallstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Jan • 22,1920 | 9. Birthplace (State or Foreign Country) | 200 | Connecticut 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M XXF 219-16-7608 Director 88 Yrs Usual Residence of Decedent 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "netural, or items 23e or 28e-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yes X X No Director Baltimore Reisterstown MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 U.S.A. 202 Conewood Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZZNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. XXNever Married 2 Married 1 ☐ Yes ŽŽNo þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BG&E Personnel Director 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any jury or other traumatic event 9008. 18. Mother's Name (First, Middle, Maiden Surname) Colin McPhail Florence Tooker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Conewood Ave. Reisterstown, MD 21136 Barbara Mielke Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State Metro Crematory Inc. 2/27/08 Baltimore, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fundral Service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 LAN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Rep Due to (or as a consequence of): Kena Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 2 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? certificate 1 ☐ Yes 2 🗹 No 200 No 1 Yes or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation death. м 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide o the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 26,2008 160 hysladn who completed cause of death (Item 23a) (Type, Print) Meisterstrum MD Ubburan I Main Street 16rc *Q*5 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 28

DHMH 17 Rev 1/200

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February25,2008 **Physician** 4:58P. M Rose Μ. Meninger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth Apr 8, 1928 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1□M 2□F Czechoslavkia 79 217-20-5665 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Harford Md. Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 621 Stone Mill Court 21009 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 💥 No Specify Be Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Crown, Cork & Seal Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Balas Susan Musinski ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 594 Forest View Road Linthicum, Md. 21090 Maria Meninger (daughter) Department of Heal Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Heart of Jesus Feb28,2008 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facil Raczorowski Funeral Home, PA 200 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence off the burial-transi Due to (or as a consequence of): attending physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2. No death? 1 ☐ Yes 2 ☐ No certificate Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Sion the Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person w

Upper Chesapake Prive Bel Air, MD 21014

no completed cause of death (Item 23a) (Type, Print)

00:6

|                                |                                                                                                                                                                                                                                                                                                   |                | For<br>State                                                            | State                        | of Marylar                       |                   | artment of<br>rtificate of            |                                         | Mental Hyg                                   | jiene            | 000                        | 0.6.1.0.0                                    |
|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------|------------------------------|----------------------------------|-------------------|---------------------------------------|-----------------------------------------|----------------------------------------------|------------------|----------------------------|----------------------------------------------|
|                                |                                                                                                                                                                                                                                                                                                   |                | State Registrar  1. Decedent's Name (First, Middle                      | . ( )                        |                                  | Cei               | uncate of                             | Dealli                                  | 2. Date of Dea                               | eg. No.          | UUB                        | 3. Time of Death                             |
|                                | Physicia                                                                                                                                                                                                                                                                                          | an             |                                                                         |                              |                                  |                   |                                       |                                         | Month                                        | Day              | Year                       |                                              |
| à                              | /Medic                                                                                                                                                                                                                                                                                            |                | Bernice M. O'No  4a. Facility Name (If not institution                  |                              | umbo rl                          |                   | 4h City Town                          | or Location of Dea                      | Feb 24,                                      | 4c. Count        | v of Death                 | 9:00 a <sup>™</sup>                          |
|                                | Examin                                                                                                                                                                                                                                                                                            | er             | Stella Maris H                                                          | -                            | inoer)                           |                   | Timoni                                |                                         | μι ι                                         | Balti            |                            |                                              |
|                                | Funoval                                                                                                                                                                                                                                                                                           |                | 5. Social Security Number                                               | 6. Sex                       | 7. Age (In yrs                   | . (ast birthday)  | If Under 1 Year                       | If Under 24 Hrs                         |                                              | 1                |                            | ace (State or Foreign<br>try)                |
| И                              | Funeral Director                                                                                                                                                                                                                                                                                  |                | 220-20-1115                                                             | 1 ☐ M 2 🔼 F                  | 81                               | Yrs.              | Months Days                           | Hours Min                               | . (Month, Day<br>02-11-                      |                  | Coun                       | MD MD                                        |
|                                | A will                                                                                                                                                                                                                                                                                            |                | Usual Residence of Decedent                                             |                              |                                  |                   |                                       |                                         |                                              |                  |                            |                                              |
|                                | rylan<br>how                                                                                                                                                                                                                                                                                      |                | 10a. State 10b. County                                                  |                              | 10c. C                           | ity, Town or Lo   | cation                                |                                         |                                              |                  | 10                         | Od. Inside City Limits                       |
|                                | e Ma<br>sa-f s<br>tified                                                                                                                                                                                                                                                                          | cto            | MD Balti                                                                | nore                         | Ki                               | ngsvill           | e                                     |                                         |                                              |                  |                            | 1 ☐ Yes 2 ☐ No                               |
|                                | or 28                                                                                                                                                                                                                                                                                             | Director       | 10e. Street and Number                                                  |                              |                                  |                   | 10f. Zip Code                         |                                         |                                              | I0g. Citizen of  | What Coun                  | try?                                         |
|                                | ath w                                                                                                                                                                                                                                                                                             | ra             | 11842 Gontrum                                                           |                              |                                  |                   | 21087                                 |                                         |                                              | USA              |                            |                                              |
|                                | er de                                                                                                                                                                                                                                                                                             | Funeral        | 11. Marital Status                                                      | Armed F                      |                                  | J.S. 13.          | Was Decedent of<br>If Yes, specify Cu | Hispanic Origin? (<br>ban, Mexican, Pue | Specity Yes or No-<br>rto Rican, etc.)       | 14. Ha           | ce - America<br>ck, White, |                                              |
| 36                             | s afte                                                                                                                                                                                                                                                                                            | by F           | 1 ☐ Never Married 2 ☐ Mar<br>3 ☑ Widowed 4 ☐ Divorced                   | If Yes. G                    |                                  |                   | 1 □ Yes 2 🖾 Ño                        | Specify:                                |                                              | Speci            | fy:                        | • • -                                        |
| 8                              | hour<br>tural<br>al Ex                                                                                                                                                                                                                                                                            | pa             | /~                                                                      | t's Education                | Dales.                           | 16a Dece          | dent's Usual Occi                     | upation                                 |                                              | 16b. Kind of E   |                            | ite                                          |
| 15                             | in 72<br>"na<br>ledic                                                                                                                                                                                                                                                                             | Completed      | (Specify only highe                                                     | st grade completed           |                                  | (Give             | kind of work don<br>DO NOT use retir  | e during most of w                      | orking                                       |                  |                            | ,                                            |
| 72                             | with<br>iene<br>r thai                                                                                                                                                                                                                                                                            | E              | Elementary/Secondary (0-12)                                             | College                      | (1-4or 5+)                       | Homen             | naker                                 |                                         |                                              | Own Ho           | ome                        |                                              |
| Baltimore, Maryland 21215-0036 | filed<br>Hyg<br>other<br>ent,                                                                                                                                                                                                                                                                     | Be C           | 17. Father's Name (First, Middle,                                       | Last)                        |                                  |                   |                                       | 18. Mother's Na                         | ame (First, Middle,                          | Maiden Surna     | me)                        |                                              |
| lan                            | ald be<br>Tenta<br>rked<br>ic ev                                                                                                                                                                                                                                                                  | To B           | Ed Keefer                                                               |                              |                                  |                   |                                       | Lillia                                  | n Keefer                                     | Schmid           | lt                         |                                              |
| ary                            | shou<br>and M                                                                                                                                                                                                                                                                                     |                | 19a. Informant's Name/Relations                                         | hip (Type. Print)            |                                  | 19b. Maili        | ng Address (Stree                     | et and Number or I                      | Rural Route Numbe                            | er, City or Town | n, State, Zip              | Code)                                        |
| Ž                              | alth alth 27 is                                                                                                                                                                                                                                                                                   |                | Dennis E. O'                                                            | Neill/Son                    |                                  | 1184              | 2 Gontr                               | um Road                                 | Kingsvil                                     | le MD 2          | 21087                      |                                              |
| Jre,                           | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. |                | 20a. Method of Disposition                                              | 0 CD                         |                                  | Place of Dispo    | sition (Name of<br>matory or other pi | lace)                                   | Date                                         | 20c. Location    | - City or To               | wn, State                                    |
| E                              | Page<br>hent c<br>nt: If                                                                                                                                                                                                                                                                          |                | 1 ☐ Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (\$                  |                              | n State G                        |                   | of Fait                               |                                         | 27-2008                                      | Baltin           | nore M                     | ID                                           |
| alti                           | mit.<br>partn<br>porta<br>y Inju                                                                                                                                                                                                                                                                  |                | 21. Signature of Funeral apvio                                          | Censee                       | ,                                | 2                 | 2. Name and Add                       | ress of Facility Se                     | chimunek                                     | Funera           | 1 Home                     | Inc.                                         |
| m                              | e a L a                                                                                                                                                                                                                                                                                           |                | PUCKE                                                                   | <b>.</b>                     |                                  | 9                 | 705 Bela                              |                                         | Nottingh                                     |                  |                            | Ziio.                                        |
|                                |                                                                                                                                                                                                                                                                                                   |                | 23a. Part1. Enter the disease, o shock, or heart failure. Lis           |                              |                                  |                   |                                       |                                         |                                              |                  |                            | Approximate<br>Interval Between              |
| V.                             | Physician                                                                                                                                                                                                                                                                                         | i              | Immediate Cause (Final disease or condition                             | A                            | thero                            | 52/-1-            | ofit C                                | 01911                                   | y V                                          | 1. U.            | 14.,-                      | Onset and Death                              |
| /                              | /Medical                                                                                                                                                                                                                                                                                          |                | resulting in death)                                                     | Due to                       | o (or as a conse                 | quence of):       | -                                     |                                         |                                              |                  |                            |                                              |
| b                              | Examiner                                                                                                                                                                                                                                                                                          |                | Sequentially list conditions,                                           | b                            |                                  |                   |                                       |                                         |                                              |                  |                            |                                              |
| -13                            | D #                                                                                                                                                                                                                                                                                               | iner           | if any, leading to immediate cause. Enter Underlying                    | Due to                       | o (or as a conse                 | equence of):      |                                       |                                         |                                              |                  |                            |                                              |
|                                | cate be executed<br>physicien and<br>the burlal-transit                                                                                                                                                                                                                                           | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last | C                            | - /                              |                   |                                       |                                         |                                              |                  |                            |                                              |
| 60,                            | oe ex                                                                                                                                                                                                                                                                                             |                |                                                                         | Due to                       | o (or as a conse                 | quence oi).       |                                       |                                         |                                              |                  |                            |                                              |
| 8760,                          | cate t<br>physic                                                                                                                                                                                                                                                                                  | dical          |                                                                         | d                            |                                  |                   |                                       |                                         |                                              |                  |                            |                                              |
| 9 x                            | ding page as                                                                                                                                                                                                                                                                                      | Me             | IF FEMALE:                                                              | 23c If yes o                 | utcome pf preg                   | nancy             |                                       |                                         |                                              | 2015             |                            |                                              |
| Box                            | death certific<br>e attending p<br>id for use as                                                                                                                                                                                                                                                  | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?                       | 1 ☐Live                      | birth 2 ☐ Fe<br>gnant at time of | tal death 3[      | Ectopic pregnar Other (specify)       |                                         |                                              |                  | ate of delive<br>Nonth     | Day Year                                     |
| o.                             | he de                                                                                                                                                                                                                                                                                             | ysic           | 1 □ Yes 2 <b>☑</b> No<br>9 □ Unknown                                    | 9☐Unk                        |                                  | death 5           |                                       |                                         |                                              |                  |                            |                                              |
| Φ.                             | w requires that the d<br>been signed by the<br>should be detached                                                                                                                                                                                                                                 |                | Part II. Other significant condit                                       | ons contributing to          | death but not re                 | esulting in the u | nderlying cause (                     | given in Part i.                        | 23e. Did to                                  | obacco use co    | ntribute to t              | he cause of death?                           |
| ds,                            | sign<br>d be                                                                                                                                                                                                                                                                                      | d by           |                                                                         |                              |                                  |                   |                                       |                                         | 1 🗆 '                                        | res 2 □ No       | 3 ☐ Prob                   | pably 4 Donknown                             |
| Ö                              | v request                                                                                                                                                                                                                                                                                         | Completed      |                                                                         |                              |                                  |                   |                                       |                                         | 24a. Was                                     | 20 24            | . Woro auto                | aney findings available                      |
| Rec                            | e la<br>has<br>je 2                                                                                                                                                                                                                                                                               | ᇤ              |                                                                         |                              |                                  |                   |                                       |                                         | - autor                                      | osy<br>rmed?     | death?                     | ppsy findings available mpletion of cause of |
| a                              |                                                                                                                                                                                                                                                                                                   |                | 25. Was case referred to medical                                        | N. I                         |                                  |                   | -                                     | 00 Di/ D                                | 1 Yes                                        | 2 2 10           | 1 🗆 Yes                    | 2 No                                         |
| or Vital Record                |                                                                                                                                                                                                                                                                                                   | Be             | examiner?                                                               | Hoopital:                    | 7 Inpatient 21                   | □ EB/Outpatio     | ot 3[] DOA C                          |                                         | eath <i>(Check only d</i><br>Home 5 Residual |                  | that (Casai                | 6.1                                          |
| o                              | Physer this eral di                                                                                                                                                                                                                                                                               | 년<br>-         | 27. Manner of Death                                                     | 28a. Dat                     | e of Injury                      | 28b. Time of      |                                       |                                         | 28d. Describe                                | _                |                            | (9)                                          |
| Division                       | Attending Ph<br>r death.<br>ector: After thi<br>by the funeral                                                                                                                                                                                                                                    | tion           | 1 Natural 5 ☐ Pendi<br>2 ☐ Accident invest                              | ng (Mo                       | onth, Day Year)                  | Injury            |                                       | lorƙ?<br>□Yes 2□No                      |                                              |                  |                            |                                              |
| /isi                           | Atter<br>deal                                                                                                                                                                                                                                                                                     | fica           | 3 Suicide 6 Could                                                       |                              | ce of injury - At                | home, farm, st    | l<br>reet, factory, offic             | e                                       |                                              |                  | nber or Run                | al Route Number,                             |
|                                | after<br>after<br>Dire                                                                                                                                                                                                                                                                            | Certification: | 4 ☐ Homicide determ                                                     | buil                         | lding, etc. (Spe                 | city)             |                                       |                                         | City or To                                   | vn, State)       |                            |                                              |
|                                | ie Hospital or Attendi<br>n 24 hours after death.<br>ie Funeral Director: A<br>bletely filled in by the fo                                                                                                                                                                                        | alC            | 29a. Certifier 12 ertifyi                                               | ng Physician: To t           | he best of my k                  | nowledge, dea     | th occurred at the                    | time, date and pla                      | ace, and due to the                          | cause(s) and     | manner as s                | stated.                                      |
|                                | To the Hos<br>within 24 hα<br>To the Fun<br>completely                                                                                                                                                                                                                                            | ledical        | (Check only 2 Medica one)                                               | I Examiner: On the<br>and ma | basis of exami<br>anner stated.  | nation and/or i   | ivestigation, in m                    | y opinion, death o                      | ccurred at the time,                         | date and plac    | e, and due t               | o ine cause(s)                               |
|                                | To the I within 24                                                                                                                                                                                                                                                                                | ž              | 29b. Signature and title of certifi                                     | er                           |                                  |                   |                                       | nse number                              |                                              | 29d. Date sig    |                            |                                              |
|                                |                                                                                                                                                                                                                                                                                                   |                | > Horr                                                                  | 7. W                         | Z                                |                   | 0                                     | 7288                                    | <                                            | 2/2              | 26/                        | 200 P                                        |
|                                | ,                                                                                                                                                                                                                                                                                                 |                | 30. Name and address of person                                          | who completed ca             | use of death (It                 | em 23a) (Type     | Print)                                |                                         |                                              |                  |                            |                                              |
|                                | 4                                                                                                                                                                                                                                                                                                 | 1              | ROBERT MOS                                                              | S, M.D.                      | 2300 DU                          | LANEY             | VALLEY R                              | OAD TIM                                 | ONIUM, MI                                    | 21093            |                            | <u> </u>                                     |
|                                | Sta                                                                                                                                                                                                                                                                                               |                | 31. Date filed (Month, Day, Yea)                                        | 8 2008 32.                   | Registrar's Sig                  |                   | 1                                     |                                         |                                              |                  |                            |                                              |
|                                | Regist                                                                                                                                                                                                                                                                                            | rar            | I LD A                                                                  | 2 2000                       | Daniel -                         | Salie A           | 33.52                                 |                                         |                                              |                  |                            |                                              |

|                                                                                                                                                                                                                                                                    |                     | For State Registrar                                                                                                                                        | State of Ma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ryland / [                          | Departme<br><i>Certifica</i>                   |                                            |                                        |                               |                                        | giene<br>Reg. No.                 | 008                                                | 06                                            | 183                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|------------------------------------------------|--------------------------------------------|----------------------------------------|-------------------------------|----------------------------------------|-----------------------------------|----------------------------------------------------|-----------------------------------------------|-------------------------|
| Physici                                                                                                                                                                                                                                                            |                     | 1. Decedent's Name (First, Middle, Las<br>ANGELA                                                                                                           | st)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | _                                   | OLIVI                                          | S - B                                      | Eγ                                     |                               | 2. Date of Dea<br>Month<br>FEBRUAR     | Day                               | Year 2008                                          | 3. Time o                                     | f Death                 |
| /Medic<br>Examin                                                                                                                                                                                                                                                   |                     | 4a. Facility Name (If not institution, give                                                                                                                | street and number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                     |                                                | y, Town, or                                |                                        |                               | FEDRUAL                                |                                   | unty of Death                                      |                                               | •                       |
| Lxamiii                                                                                                                                                                                                                                                            |                     | THE JOHNS HOPKIN                                                                                                                                           | 5 HOSPITA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | L                                   | BA                                             | LTIM                                       | ORE                                    | C                             | ITY                                    |                                   | N/A                                                |                                               |                         |
| Funeral<br>Director                                                                                                                                                                                                                                                |                     | 5. Social Security Number 6. S 212-92-4779                                                                                                                 | ex 7. Age<br>□M 2X☐F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (In yrs. last bii<br>40             |                                                | ler 1 Year                                 | If Under<br>Hours                      | 24 Hrs.<br>Min.               | 8. Date of Birt<br>(Month, Da<br>10-23 | h<br>y, <sub>Year)</sub><br>-1967 | Cou                                                | place (State<br>untry)<br>RYLAND              |                         |
| and **                                                                                                                                                                                                                                                             |                     | Usual Residence of Decedent  10a. State 10b. County                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10c. City, Tow                      | m or Location                                  |                                            |                                        |                               |                                        |                                   |                                                    | 10d. Inside C                                 | City Limits             |
| Maryl.                                                                                                                                                                                                                                                             | ō                   | MD. N/A                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | BAL                                 | TIMORE                                         |                                            |                                        |                               |                                        |                                   |                                                    | 1 ∑ Yes                                       | 2 🗆 No                  |
| r 286                                                                                                                                                                                                                                                              | rec                 | 10e. Street and Number                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                     | 10f. 2                                         | Zip Code                                   |                                        |                               |                                        | 10g. Citizer                      | n of What Cou                                      | untry?                                        |                         |
| death with the Maryland<br>ms 23a or 28e-f show<br>rmust be notified at                                                                                                                                                                                            | ai D                | 3927 CLARKS LANE                                                                                                                                           | E .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                     |                                                | 2121                                       | 5                                      |                               |                                        |                                   | USA                                                |                                               |                         |
| ife, INTAINING ZIZIOUSO  s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene Item 27 is marked other then "natural", or items 23s or 28e-1 show other treumatic event, the Medical Exercises must be indifficated. | by Funeral Director | 11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced                                                                                          | 12. Was Decedent E-<br>Armed Forces?<br>1 Yes 2 XNo<br>If Yes, Give<br>Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                     |                                                | cedent of Hoecify Cuba<br>2 X No           | ispanic Ori<br>in, Mexicar<br>Specify: |                               | cify Yes or No<br>Rican, etc.)         |                                   | Race - Amer<br>Black, White<br>pecify: BL          | , etc.                                        |                         |
| Lhin 72 ho                                                                                                                                                                                                                                                         | Completed           | 15. Decedent's Ed<br>(Specify only highest gra                                                                                                             | ide completed)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                     | Decedent's U:<br>(Give kind of<br>life. DO NOT | sual Occupa<br>work done of<br>use retired | ation<br>during mos                    | t of working                  | ng                                     | 16b. Kind                         | of Business/li                                     | Business/Industry                             |                         |
| o filed within al Hygiene.                                                                                                                                                                                                                                         | mo.                 | Elementary/Secondary (0-12) -12-                                                                                                                           | College (1-4or 5+                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | -)                                  | JANITO                                         | RIAL                                       |                                        |                               |                                        | SOC                               | IAL SE                                             | CURITY                                        |                         |
| nd Z<br>e filed<br>al Hygid<br>lother<br>vent, t                                                                                                                                                                                                                   | Be C                | 17. Father's Name (First, Middle, Last)                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                     |                                                |                                            | 18. Mothe                              | er's Name                     | (First, Middle,                        | Maiden Su                         | mame)                                              |                                               |                         |
| Maryland 2 should be fill 1 and Mental H; 1 e marked oth                                                                                                                                                                                                           | To I                | HASKELL WALLACE                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                     |                                                |                                            |                                        |                               | BARNET                                 |                                   |                                                    |                                               |                         |
| mand 2 sh<br>and 2 sh<br>ealth and<br>m 27 le m                                                                                                                                                                                                                    |                     | 19a. Informant's Name/Relationship ( KAREN WILKINS (MC                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 198                                 | -                                              |                                            |                                        |                               |                                        | OUTH CAROLINA 29516               |                                                    |                                               |                         |
| os 1 ar<br>of Hea<br>Item ?                                                                                                                                                                                                                                        |                     | 20a. Method of Disposition                                                                                                                                 | of Disposition (A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | lame of                             |                                                |                                            | ate                                    |                               | tion - City or 1                       |                                   |                                                    |                                               |                         |
| Pages<br>Pages<br>ment of I                                                                                                                                                                                                                                        |                     | 1 ☐ Burial 2 ☑ Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specif                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                     | CREMAT                                         |                                            |                                        | -21-2                         |                                        |                                   | IMORE,                                             |                                               | AND                     |
| Baltimore, permit. Pages 1 an Deportment of Heal Important: if item 2 any njury or other                                                                                                                                                                           |                     | 21. Signature / Eur ral Service Uper                                                                                                                       | JONATHAN . C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | D. HII                              | BN 🕰 Name<br>1721                              |                                            |                                        |                               | DD FUNE<br>ST. BAL                     |                                   |                                                    |                                               | 21217                   |
| Pnysician<br>/Medical                                                                                                                                                                                                                                              |                     | 23a. Part / Enter the disease, or com<br>short or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)        | one cause on each line<br>a.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | DISS                                | EMIN                                           | •                                          | -                                      |                               |                                        |                                   | US                                                 | Approxima<br>Interval Be<br>Onset and<br>3 we | Death                   |
| be executed ician and burial-transit                                                                                                                                                                                                                               | edicai Examiner     | Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last | c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | IMMUNODEFICIENCY a consequence of): |                                                |                                            |                                        |                               | JIRU                                   | S                                 |                                                    | 4 yea                                         | ers                     |
| .C. BOX 68/1. the death certificate y the attending phys ched for use as the                                                                                                                                                                                       | Physician/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                                                    | 23c. If yes, outcome of the control | 2 Fetal death                       | Fetal death 3 Ectopic pregnancy                |                                            |                                        |                               |                                        | 23d. C                            |                                                    |                                               | Year                    |
| cords, F.C. w requires that the di been signed by the should be detached                                                                                                                                                                                           | by                  | Part II. Other significant conditions of                                                                                                                   | ontributing to death bu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | t not resulting                     | in the underlyin                               | g cause giv                                | en in Part I                           | l.                            |                                        | obacco use                        | contribute to                                      |                                               | death?<br>]Unknown      |
| The lay                                                                                                                                                                                                                                                            | Completed           |                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                     |                                                |                                            |                                        |                               | 24a. Was<br>auto<br>perfo<br>1 Tyes    |                                   | 24b. Were au<br>prior to death?<br>1 \( \text{Yes} | completion of                                 | s available<br>cause of |
|                                                                                                                                                                                                                                                                    | o Be                | 25. Was case referred to medical examiner?                                                                                                                 | Hospital:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                     |                                                | Oth                                        | er                                     |                               | (Check only                            |                                   | 704                                                | - ( )                                         |                         |
| On Or<br>ding Phys<br>h.<br>After this<br>funeral di                                                                                                                                                                                                               | $\vdash$            | 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio                                                                                | 28a. Date of Injury<br>(Month, Day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                     | utpatient 3   Time of Injury                   | 28c. Injur<br>Wor                          | 4 LIN                                  | 2                             | me 5 🗌 Resi<br>28d. Describe           |                                   |                                                    | cify)                                         |                         |
| To the Hospital or Attending Proving to the Hospital or Attending Proving after death.  To the Funeral Director: After to completely filled in by the funeral                                                                                                      | Certification:      | 2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined                                                                                      | e One Diese of lein                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                     |                                                |                                            |                                        | 28f. Location (<br>City or To |                                        | Vumber or Ru                      | ural Route Nu                                      | mber,                                         |                         |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier and manner stated.                                                                                                                                         |                     |                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                     |                                                | nd place, a<br>ath occurre                 | and due to the<br>ed at the time,      | cause(s) ar<br>date and pl    | nd manner as<br>lace, and due          | stated.<br>to the cause           | (s)                                                |                                               |                         |
| To the                                                                                                                                                                                                                                                             |                     |                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                     |                                                |                                            |                                        |                               | signed (Montl                          | h, Day, Year)                     |                                                    |                                               |                         |
|                                                                                                                                                                                                                                                                    |                     | > Ellian                                                                                                                                                   | M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                     |                                                | RE.                                        | 5-0                                    | 000                           |                                        | FEBRU                             | ARY 1                                              | 7, 200                                        | 08                      |
| 2                                                                                                                                                                                                                                                                  |                     | 30. Name and address a person who                                                                                                                          | ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                     | . , .                                          |                                            |                                        |                               |                                        |                                   |                                                    |                                               |                         |
| ⊸ Sta                                                                                                                                                                                                                                                              | to.                 | 31. Date filed (Month, Day, Year)                                                                                                                          | 32 Degistra                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | r's Signature -                     | 00 100                                         | ii. Wolf                                   | E ITA                                  | EET,                          | BALTIMO                                | RE, M                             | N. L. N.                                           | 2 2 1                                         | 37                      |
| Registi                                                                                                                                                                                                                                                            |                     | FEB 2 8 2                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | K                                   | BORALL                                         |                                            |                                        |                               |                                        |                                   |                                                    |                                               |                         |

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------|----------------------------------------------------------------|-------------------------|--------------------------------------------------------------------|--------------------|--------------|-------------------------------------|---------------------|------------------------------------------|------------------------------------------------------|
| Physicia<br>/Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                 | 1. Decedent's Nam<br>HERMAN                                                                                 |                                                     | ast)<br>DALE                  | PENN                                                           | NINGTO                  |                                                                    |                    |              | 2. Date of De<br>Month<br>FEBRUA    | ath<br>Day          | Year<br>5 200                            | 3. Time of Death 8 : 45A M                           |
| Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | -               | 4a. Facility Name (#                                                                                        | f not institution, g                                |                               | imber)                                                         |                         | 4b. City, Town,                                                    | or Location        | of Death     |                                     |                     | unty of Death                            |                                                      |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                 | 5. Social Security N 214-26-                                                                                | 9153                                                | Sex<br>1 ☑ M 2 □ F            | 7. Age (In yrs.                                                | 75 Yrs.                 | If Under 1 Year<br>Months Days                                     |                    | Min.         | 8. Date of Bir (Month, Da 1 0 - 2 - | y, Year)            | 9. Birth<br>Cou<br>WE:                   | place (State or Foreign<br>Intry)<br>ST VIRGINI      |
| -f show<br>fied at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | tor             | Usual Residence of<br>10a. State<br>MD                                                                      | 10b. County                                         | LTIMORE                       |                                                                | y, Town or Lo           |                                                                    | LE R               | IVER         |                                     |                     |                                          | 10d. Inside City Limits 1 ☐ Yes ¾☐ No                |
| 23a or 28a<br>ist be noti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | al Director     | 10e. Street and Nu.                                                                                         |                                                     | D                             |                                                                |                         | 10f. Zip Code                                                      | 1220               |              |                                     | 10g. Citizen        | of What Cou                              | •                                                    |
| al", or Items                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | by Funeral      | 11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed                                                               | ried 2□ Married                                     | Armed Fo                      | cedent Ever in U<br>orces?<br>2 No<br>ive<br>Dates: 195(       |                         | Vas Decedent of<br>f Yes, specify Cu<br>I ☐ Yes 2☑ N               |                    |              | ecify Yes or No<br>Rican, etc.)     |                     | Race - Amer<br>Black, White<br>ecify: W] |                                                      |
| Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Completed       | (Spec                                                                                                       | 15. Decedent's cify only highest gondary (0-12)     | Education<br>trade completed) |                                                                | 16a. Deced              | lent's Usual Occ<br>kind of work don<br>OO NOT use retii<br>TECHNI | e during mo<br>ed) | ost of worki | ing                                 | MARY                | of Business/I<br>LAND                    | •                                                    |
| Mental Hyg<br>arked other<br>atic event,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | To Be C         | 17. Father's Name STANFO                                                                                    |                                                     | st)                           | PENNIN                                                         | IGTON                   |                                                                    | 18. Moth           |              | (First, Middle<br>PEARL             | , Maiden Sur        |                                          |                                                      |
| m 27 is me traums                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                 | 19a. Informant's N                                                                                          | ERENDE                                              |                               |                                                                | 416                     | g Address (Stree<br>EARLS                                          |                    | M            | IDDLE                               | RIVER               | R, MD                                    | 21220                                                |
| rtment of h                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                 | 4 ☐ Donation                                                                                                | ☐Cremation 3<br>5☐Other (Spe                        | cify)                         | State                                                          | cemetery, crer<br>RDENS | sition (Name of natory or other p                                  | ТН                 | 3-           | Date<br>1 – 2008                    | BALT                |                                          | E, MD                                                |
| Depa<br>Impo<br>any ir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                 | 21. Signature of Fi                                                                                         | 0                                                   |                               | Caused the deat                                                | 12                      | 11 CHE                                                             | SACO               | AVE          | ROS                                 | EDALE               |                                          | NERAL HOME 21237 Approximate                         |
| hysician<br>/Medical<br>xaminer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                 | shock, or hea<br>shock, or hea<br>Immediate Cause<br>disease or condition<br>resulting in death)            | art failure. List on<br>(Final<br>on                | ly one cause on               | each line.                                                     | TALK                    | Em Pry                                                             |                    |              | or respiratory a                    | irest,              | OVAK                                     | Interval Between Onset and Death                     |
| ohysician and the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | al Examiner     | Sequentially list concause. Enter Unde<br>Cause (Disease or<br>that initiated events<br>resulting in death) | erlying<br>injury                                   | c                             | for as a consequence (or as a consequence                      |                         |                                                                    |                    |              |                                     |                     |                                          |                                                      |
| certificate has been signed by the attending physrector, page 2 should be detached for use as the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ysician/Medical | IF FEMALE:<br>23b. Was deceden<br>in the past 12<br>1 ☐ Yes 2 I<br>9 ☐ Unknown                              | ! months?<br>□ No                                   | 1□Live                        | utcome pf pregn<br>birth 2  Feta<br>gnant at time of c<br>nown | al death 3□             | Ectopic pregnar                                                    | су                 |              |                                     | 23d.                | . Date of deli                           | very<br>Day Year                                     |
| en signed by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ed by Phy       | Part II. Other signi                                                                                        | ficant conditions                                   | contributing to c             | death but not res                                              | ulting in the u         | nderlying cause (                                                  | jiven in Part      | t I.         | 23e. Did                            |                     |                                          | the cause of death?                                  |
| cate has been page 2 sho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Completed       |                                                                                                             | <del> </del>                                        |                               |                                                                |                         |                                                                    |                    |              | 24a. Was<br>auto<br>perfe<br>1 Yes  |                     | prior to death?                          | topsy findings available completion of cause of 2 No |
| r this certifi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | To Be           | 25. Was case reference examiner? 1 ☐ Yes 2 ☑ 27. Manner of Dear                                             | (No                                                 | Hospital: 1 28a. Date         |                                                                | ER/Outpatien            | 1 3 DOA                                                            | ther: 4 🗆 N        | Nursing Ho   | me 5 Res<br>28d Describe            | idence 6            |                                          | cify)                                                |
| within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ertification:   | 1 XNatural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide                                                            | 5 Pending<br>investigat<br>6 Could not<br>determine | on (Mon                       | nth, Day Year)<br>e of injury - At h<br>ding, etc. (Specia     | Injury ome, farm, str   | M 1                                                                | Yes 2              | □No          | 28f. Location (                     | Street and N        |                                          | ıral Route Number,                                   |
| within 24 hours after death.  To the Funeral Director: A completely filled in by the formula in | edical Cer      |                                                                                                             |                                                     |                               |                                                                |                         |                                                                    |                    |              |                                     |                     | to the cause(s)                          |                                                      |
| within<br>To th<br>comp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Me              | 29b. Signature and                                                                                          | title of certifier                                  |                               | 80                                                             |                         | 29c. Lice                                                          | nse number         | 122          | /                                   | 29d. Date s         | igned (Monti                             | h, Day, Year)                                        |
| 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                 | 30. Name and add                                                                                            | ress of person wh                                   | o completed                   | se of death (Iter                                              | n 23a) (Type,           | Print)<br>B. Bho                                                   | BAL                | 17           | 40 21                               | 22/                 |                                          |                                                      |
| Sta<br>Registr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 | 31. Date filed (Mor                                                                                         | FEB 2 8                                             | 2008 32.                      | Registrar's Signa                                              | ature                   | medi                                                               |                    |              |                                     |                     |                                          |                                                      |

| hilip Reeve                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | s Pa                               |               | m Sta<br>1- For State<br>Registrar                              | ate of Maryland /                            |                    | artment of<br><i>rtificate of</i> |                      |               | Menta             | al Hy     |                                       | g. No. 200                          | 8-06185                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------|-----------------------------------------------------------------|----------------------------------------------|--------------------|-----------------------------------|----------------------|---------------|-------------------|-----------|---------------------------------------|-------------------------------------|---------------------------------------------------------------|
| Phys<br>ledical Exa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                    | ın/           | 1. Decedent's Name (First, Middle Philli                        |                                              | arha               | m                                 |                      |               |                   |           | Date of Death<br>Month<br>February 2  | )                                   | 3. Time of Death                                              |
| ert.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b></b>                            |               | 4a. Facility Name (if not institution                           | •                                            | ai na              |                                   | 4b. City,            | Town, or L    | ocation of        |           | February 2                            | 2, 2008<br>4c. County of D          |                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                    |               | 403 Manchester Road                                             |                                              |                    |                                   |                      | ytown         |                   |           |                                       | Carroll                             |                                                               |
| Fune<br>Direc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                    |               | 5. Social Security Number 217–44–9131                           |                                              | e (In yrs. I<br>60 | ast birthday)                     | Month                | ler 1 Year    | if Under<br>Hours | Min       |                                       | Fo                                  | . Birthplace (State or oreign                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                    | ł             | Usual Residence of Decedent                                     | 1 AM 2 F                                     | 00                 | Yrs                               |                      |               |                   |           | May 5,                                | 1947                                | Country) MD                                                   |
| 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | î di                               | Ì             | 10a. State 10b. County                                          | 3.3                                          | 10c. City,         | Town or Locat                     |                      |               |                   |           |                                       |                                     | 10d. Inside City Limits                                       |
| yland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | dat once.                          | į             | MD Cari                                                         | roll                                         |                    |                                   |                      | ytown         |                   |           | Tao                                   | - Chinas of Mhat                    | 1 Yes 2 X No                                                  |
| he Mar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | notified at once.                  | Director      | 2893 E. Mayber                                                  | cry Road                                     |                    |                                   | 10f. Zip             |               | 21787             | 7         | 100                                   | g. Citizen of What<br>US            |                                                               |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Henalth and Mornell Hygiens. Financy and The Results of Anther than "marging" or items 32s are 38s, felt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | be not                             |               | 11. Mantal Status                                               | 12. Was Decedent                             |                    |                                   |                      | ent of Hisp   | anic Origin       | n? (Spe   | cify Yes or No-                       | 14. Race - A                        | merican Indian, Black,                                        |
| er deatl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | r must                             | Funeral       | 1 Never Married 2 Married 3 Widowed 4 Dive                      | IIIieu -                                     | No                 | 1                                 |                      | ify Cuban,    |                   | -uerto R  | ican, etc.)                           | White, et                           |                                                               |
| ours afte                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | amine                              | d b           | 15. Decedent's Education (Spec                                  | or Dates:                                    |                    | 16a. Deceden                      | nt's Usual           | Occupation    | n (Give kir       |           |                                       | Specify:<br>16b. Kind of Busine     | White<br>ess/Industry                                         |
| 6<br>11 72 ho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ical Ex                            | ompleted      | Elementary/Secondary (0-12)                                     | College (1-4 or 8                            | 5+)                |                                   |                      | rking life. [ |                   | se retire | ed)                                   |                                     |                                                               |
| -003<br>1 within<br>giene.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | e Med                              | E O           | 12 17. Father's Name (First, Middle,                            | l ast)                                       |                    | Disa                              | bled                 | Vete          |                   | Name (    | First Middle M                        | None                                |                                                               |
| 21215-0036 vald be filed within 7 Mental Hygiene.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ent, th                            | Bec           | Paul Reeves I                                                   | ,                                            |                    |                                   |                      | "             |                   |           | Irene (                               |                                     |                                                               |
| D 21<br>should<br>and Me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | atic ev                            | 유             | 19a. Informant's Name/Relationsh<br>Nancy K. Parhan             |                                              |                    |                                   |                      |               | and Numb          | er or Ru  | ral Route Num                         | ber, City or Town, S                |                                                               |
| Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important. If the 2 permit and 2 should be also p | traum                              |               | 20a. Method of Disposition                                      | - (wite)                                     | 20b.               | Place of Dispos                   |                      |               |                   |           | Date                                  | own, MD 2                           |                                                               |
| nore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | othe                               |               | 1 X Burial 2 Cremation 4 Donation 5 Other Sp                    |                                              | Ga:                | crematory or ot<br>rrison         | <sup>her place</sup> | e)<br>st Ve   | t Cen             | n. 2      | /27/08                                | Owings 1                            | Mills, MD                                                     |
| trmit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | jury o                             | 1             | 21. Signature of Funeral Service I                              | Licensee                                     |                    |                                   |                      |               |                   |           |                                       |                                     |                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                    |               | 23a. Part I. Enter the disease, or                              | Waight A                                     | 1007               | Bo not optor                      | x 19                 | 5 Syk         | esvil             | lle,      | MD                                    | EL, P.A.                            | Approximate Interval                                          |
| Physici<br>/Medi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | cal                                |               | failure. List only one cause                                    | on each line.                                |                    |                                   |                      | 172-          |                   |           | <b>ntoxica</b>                        |                                     | Between Onset and<br>Death                                    |
| -xamir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ner                                |               | immediate Cause (Final disease or condition resulting in death) | Due to (or as a conse                        |                    |                                   | cusc                 |               |                   |           |                                       |                                     |                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                    | ٦             | Sequentially list conditions, if any, leading to immediate      | b<br>Due to (or as a conse                   | equence o          | of):                              |                      |               |                   |           |                                       |                                     |                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ۹                                  | Examiner      | cause. Enter Underlying Cause (Disease or injury that initiated | c                                            | auonao a           | of).                              |                      |               |                   |           |                                       |                                     |                                                               |
| J cated                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | transit                            |               | events resulting in death) Last                                 | d                                            | squerice c         | ,,,                               |                      |               |                   |           |                                       |                                     |                                                               |
| D,<br>be exe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | nysician and<br>e burial - transit | Medical       | UNPENDED                                                        | AMENDED 23                                   | a, 2               | 7, 28a-                           | f pe                 | r we          | g8 <b>7</b> 9     | 5-6       | -08 vt                                |                                     |                                                               |
| 876(<br>tificate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ng pny<br>as the b                 | M/u           | IF FEMALE:<br>23b. Was decedent pregnant in the                 | 23c. If yes, outcome 1 Live birth            | ne of preg         |                                   | etal death           | 3             | Ectopic p         | pregnan   | cy                                    | 23d. Date of de<br>Month            | elivery<br>Day Year                                           |
| OX 6<br>ath cer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | for use as the                     | Physician/    | past 12 months?  1 Yes 2 No 9 Unk                               | 4 Pregnant at                                | time of de         | noth =                            | ther (Spe            |               |                   |           |                                       |                                     |                                                               |
| rtthe de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | chec                               |               | Part II. Other significant conditi                              | 9 Onknown                                    | but not r          | esulting in the t                 | underlyin            | g cause giv   | ven in Part       | t J.      | 23e. Did to                           | bacco use contribu                  | ite to the cause of death?                                    |
| s, P.(                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | hould be deta                      | d b           |                                                                 |                                              |                    |                                   |                      |               |                   |           | 1 Yes                                 | 2 No 3                              | Probably 4 Unknown                                            |
| ords<br>w requ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 2 should                           | ompleted      | Ű                                                               |                                              |                    |                                   |                      |               |                   |           | 24a. Was a<br>autop                   | sy prio                             | re autopsy findings available<br>or to completion of cause of |
| tal Rec<br>tian: The la                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                    | O             | 0                                                               |                                              |                    |                                   |                      |               |                   |           |                                       |                                     |                                                               |
| <b>/ital</b><br>sician:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | the funeral director, page         | Be            | 25. Was case referred to medical examiner?                      | Hospital: 1 Inpatie                          | nt 2               | ER/Outpatient                     | 3 1                  | 26.Place o    | Mhon ==           |           | <u></u> -                             | Residence 6 🗸                       | Other: Scene                                                  |
| of V<br>ng Phy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | meral d                            | 11            | 1 ✓ Yes 2 No<br>27. Manner of Death                             | 28a. Date of Inju<br>(Month, Day,Y           | ry                 | 28b. Time of I                    |                      | 28c. Injury   |                   |           |                                       | now injury occurred                 |                                                               |
| sion<br>ttendii<br>death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                    | atio          | Pend 2 Accident Inves                                           |                                              |                    | 11:30                             | а                    | 1Y6           | es 2 <b>X</b> 1   |           | unknow                                |                                     |                                                               |
| Divis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | filled in by                       | ertification: | deter                                                           | d not be 28e. Place of In                    | _                  | ome, farm, stre                   | et, factor           | y, office bu  | ilding, etc.      |           | 28f. Location (S<br>or Town, S        | treet and Number of<br>tate)403 Mar | or Rural Route Number, City                                   |
| Hospit<br>24 hour<br>Funers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                    | 0             | 4 Homicide                                                      | ysician: To the best of m                    | -                  |                                   | rred at th           | e time, date  | e and plac        | e, and c  |                                       |                                     | s stated.                                                     |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | completely                         | Medical       | one) 2 Medical Exam                                             | niner:On the basis of examend manner stated. |                    |                                   | tion, in m           | y opinion,    | death occu        |           |                                       | and place, and due                  | to the cause(s)                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                    | Σ             | 29b. Signature and title of certifier                           |                                              |                    |                                   | 29                   | o.C.N         |                   |           |                                       | 29d. Date signed February 23,       | (Month, Day, Year)                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                    |               | 30. Name and address of person                                  | Who completed cause of a                     | eath (Item         | 1 23a)                            |                      | 0.0.10        |                   |           | · · · · · · · · · · · · · · · · · · · | , coluary 23,                       |                                                               |
| H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                    |               | Pamela E. Southall, M                                           |                                              | ,                  | ,                                 | 1 Penr               | n Street,     | Baltimo           | ore, M    | D 21201                               |                                     |                                                               |
| Po                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | St                                 | _             | 31. Date filed (Month, Day, Year)                               | 32. Registr                                  | 's Signati         | ure                               | A434                 | A. 3.         | _                 |           |                                       |                                     |                                                               |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary R. Provenzano /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Union Memorial Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 06/04/191 (ear) 1 □ M 2 🔀 F Days Hours Min. 96 213-30-7768 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at Director N/A Baltimore 1 X Yes 2 □ No Maryland 10f. Zip Code 21214 10g. Citizen of What Country? 10e. Street and Number 5102 Harford Road Completed by Funeral 14. Race - American Indian, 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Nidowed 4 Divorced "natural", 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Megane. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Concettina Scarlatta Santo Ceccio ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1190 W. Northern Parkway Apt.324 Baltimore, Maryland 21210 Rose Provenzano - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Glen Haven Memorial Garden 02/27/2008 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** meumonio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Physician/Medical the use as attending IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 █ No
9 ☐ Unknown for Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be c Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an N autopsy page certificate 1□ Yes or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ FB/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural
2 Accident 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

P.O. Box 68760, or Vital Records, To the Hospital within 24 hours a

> State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Yea)

2008

82. Registrar's Signature

29c. License number

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LINCOLN PERSON 23-13 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner fal - 01 Sulpinore City more If Under 1 Year | If Under 24 Hrs Social Security Number Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign **Funeral** Months 1√2 M 2□F Hours NEW YORK 79 230-30-2708 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 1 TyYes 2 □ No Director N/A MD. BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3510 KESTON RD Funeral 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DANo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) LABORER RAILROAD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PAUL PERSON JANIE FERGUSON ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NELLIE PERSON (WIFE) 3510 KESTON RD. BALTIMORE. MARYLAND 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremat 3 Removal from State ARBUTUS MEMORIAL PARK 2-27-2008 BALTIMORE, MARYLAND 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service Accesses ONATHAN HIBNER A. Name and Address of Facility PHILLIPS FUNERALP. A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat ause (Final disease of ondition resulting in death) Sepsis. Physician week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 organ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed bowe 005 心ん 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an Gasho intes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred al or Attending P after death. i Director: After t 5 Pending investigation To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) S. MUNIREDPY M.D 23 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MUNIREDDY Sigar Hospital ANJAY

State Registrar 31. Date filed (Month, Day, Year) FEB 2 8 2008 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician SABELD RIOS rebruary 18 2008 6:12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Secours Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 8, 19 9. Birthplace (State or Foreign Country) Puerto Rico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days 1 M 2 □ F 62 1945 581-82-9664 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 □ No Directo Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 541 S. Monroe Street 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 X Yes 2 ☐ No Specify: Puerto Rican ģ Specify: white 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) disabled none 4 unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 541 S. Monroe Street Baltimore, MD Caroline Sears/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 1 Other () Specify) in state 21. Signature of Euneral S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedi le Cause (Final disease le condition resulting in death) Speci **Physician** ocardia Õ /Medical ue to (or a a consequence of) Examiner ercosc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) or Vital Records, P.O. Box 68760, physician Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Denknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 2 No 1□ Yes Physiclan: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ N 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Injury 1 Natural 5 Pending investigation 1 Tes death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital or Attending 124 hours after death.

The Funeral Director: Poletely filled in by the fi within 24 hou To the Fune completely fi

State

29a. Certifier

(Check only one)

2000 W.

au)

and manner stated.

29c. License number 10034730 29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Baltimore Street

tebruary Balli MD 21223

31. Date filed (Month, Day, Year) FEB28

29b. Signature and title of certifier

Registrar

Medical

DHMH 17 Rev 1/2001

Registrar

|                |                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Please Type or                                                                                              |                                        |                                                    |                                          |                                             | •                                 |                                    |                                                  |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------|------------------------------------------|---------------------------------------------|-----------------------------------|------------------------------------|--------------------------------------------------|
|                |                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1 _ State                                                                                                   | of Marylar                             |                                                    | artment of F<br><i>rtificate of</i>      | lealth and N                                | , ,                               | 0000                               | 05190                                            |
|                |                                                                                                                                                                           | g                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Registrar  1. Decedent's Name (First, Middle, Last)                                                         |                                        |                                                    | rimoate or                               | Death                                       | 2. Date of Deat                   | n No                               | 3. Time of Death                                 |
|                | Physicia<br>/Medic                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Rose Marie Rocca                                                                                            |                                        |                                                    |                                          |                                             | Feb 23,                           | Day Year<br>2008                   | 8:30 a M                                         |
|                | Examin                                                                                                                                                                    | of since                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and nu                                                   | mber)                                  |                                                    | 4b. City, Town, o                        | r Location of Death                         |                                   | 4c. County of Deat                 |                                                  |
| * <b>3</b> 5   | <u> </u>                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1509 Weyburn Rd.  5. Social Security Number 6. Sex                                                          | 7. Age (In yrs.                        | last hirthday)                                     | Rosedale                                 |                                             | 8. Date of Birth                  | Baltimor                           | e<br>hplace (State or Foreign                    |
| ь.             | Funeral Director                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 216-16-6416 1□M 2 <sup>M</sup> F                                                                            | 84                                     | Yrs.                                               | Months Days                              | Hours Min.                                  | (Month, Day, 12-02-1              | Year) Co                           | Pa                                               |
| - 10           | 0                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                                 |                                        |                                                    |                                          |                                             | 12 02 1                           | 323                                |                                                  |
|                | arylar<br>show                                                                                                                                                            | 'n                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10a. State 10b. County                                                                                      |                                        | ty, Town or Lo                                     |                                          |                                             |                                   |                                    | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No           |
|                | the M                                                                                                                                                                     | Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | MD Baltimore  10e. Street and Number                                                                        | Ro                                     | sedale                                             | 10f. Zip Code                            |                                             | 11                                | 0g. Citizen of What Co             |                                                  |
| :              | 3a or<br>st be                                                                                                                                                            | Ö                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1509 Weyburn Road                                                                                           |                                        |                                                    | 21237                                    |                                             |                                   | USA                                |                                                  |
|                | ems 2                                                                                                                                                                     | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11. Marital Status 12. Was Dec                                                                              | edent Ever in U                        | J.S. 13.                                           |                                          | Hispanic Origin? (Sp<br>an, Mexican, Puerto |                                   | 14. Race - Ame<br>Black, Whit      |                                                  |
| 9              | s after<br>; or Ita                                                                                                                                                       | by Fu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1 Never Married 2 Married 1 Yes                                                                             | 2 <b>™</b> No<br>ive                   |                                                    | 1 ☐ Yes 2 No                             | Specify:                                    | The Land                          | Specify:                           |                                                  |
| 2-0036         | tural'<br>al Ex                                                                                                                                                           | q pa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 3 ☑ Widowed 4 ☐ Divorced Year or I                                                                          | Dates:                                 | 16a. Dece                                          | dent's Usual Occup                       | pation                                      | - 1                               | 16b. Kind of Business              | hite                                             |
| 215            | hin 72<br>9.<br>In "ns<br>Medir                                                                                                                                           | plet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (Specify only highest grade completed)                                                                      | 1-4or 5+)                              | (Give                                              | kind of work done<br>DO NOT use retire   | during most of work<br>d)                   | ting                              |                                    | ,                                                |
| 21             | be filed within 72 hours after death with the Maryland half Hygiene. Ale other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Completed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10                                                                                                          |                                        | Tail                                               | .or                                      |                                             |                                   | Clothing                           |                                                  |
| and<br>ind     | d tal                                                                                                                                                                     | Be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)                                                                     |                                        |                                                    |                                          |                                             | , ,                               | Maiden Surname)                    |                                                  |
| Maryland 2121  | should be<br>and Menta<br>marked<br>umatic ev                                                                                                                             | ည                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Salvadore Mazzie  19a. Informant's Name/Relationship (Type. Print)                                          |                                        | 19h Maili                                          | ing Address (Street                      |                                             | iGorgio                           | ; City or Town, State, .           | Zin Code)                                        |
| B<br>S         | and 2 sho<br>ealth and<br>n 27 is ma<br>ier trauma                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Frances D'Adamo/Daughte                                                                                     | r                                      |                                                    |                                          | Rd. Rose                                    |                                   | •                                  | Lip Gode)                                        |
| Φ.             | - I 5 =                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from                                             | 20b.                                   | Place of Dispo<br>cemetery, cre                    | osition (Name of<br>ematory or other pla | ce)                                         | Date                              | 20c. Location - City or            | Town, State                                      |
| Ĕ.             | Pages<br>ment of l<br>ant: If Its<br>lury or o                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4 □ Donation 5 □ Other (Specify)                                                                            | State                                  | st Hol                                             | y Redeeme                                | er 02-2                                     | 27-2008 1                         | Baltimore                          | MD                                               |
| Sali           | permit. Pag<br>Department<br>Important: I<br>any Injury o<br>once.                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Signature of Funeral Service Licensee                                                                   |                                        |                                                    | 2. Name and Addre                        | υ.                                          |                                   | Funeral H                          | ome Inc.                                         |
|                | 482 % 6                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23a. Part1. Enter the disease, or complications that                                                        | MD 21236                               | Approximate                                        |                                          |                                             |                                   |                                    |                                                  |
|                | hysician                                                                                                                                                                  | 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | shock, or heart failure. List only one cause on<br>Immediate Cause (Final                                   | R                                      | Approximate<br>Interval Between<br>Onset and Death |                                          |                                             |                                   |                                    |                                                  |
| No.            | /Medical                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | disease or condition resulting in death) a                                                                  |                                        |                                                    |                                          |                                             |                                   |                                    |                                                  |
| ĸ.             | Examiner                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Sequentially list conditions. b                                                                             |                                        |                                                    |                                          |                                             |                                   |                                    |                                                  |
|                | pe tisi                                                                                                                                                                   | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury |                                        |                                                    |                                          |                                             |                                   |                                    |                                                  |
|                | oe executed<br>cian and<br>ourial-transit                                                                                                                                 | xan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | that initiated events c                                                                                     |                                        |                                                    |                                          |                                             |                                   |                                    |                                                  |
| 760,           | The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                             |                                        |                                                    |                                          |                                             |                                   |                                    |                                                  |
| Box 687        | leath certificate be<br>attending physici<br>I for use as the bu                                                                                                          | Physician/Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | IF FEMALE:                                                                                                  |                                        |                                                    |                                          |                                             | <del></del>                       |                                    |                                                  |
| go.            | ath ce<br>ttendi<br>or use                                                                                                                                                | ian/I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 23b. Was decedent pregnant in the past 12 months?                                                           | atcome pf pregr<br>birth 2 ☐ Fet       | tal death 3[                                       | □Ectopic pregnanc                        | ey .                                        |                                   | 23d. Date of de<br>Month           | livery<br>Day Year                               |
| P.0.           | ires that the de<br>signed by the a<br>I be detached f                                                                                                                    | ysic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1 Yes 2 No 4 Prec<br>9 Unknown 9 Unk                                                                        | nant at time of                        | death 5                                            | Other (specify) _                        |                                             |                                   |                                    | ,                                                |
| <b>.</b>       | s that<br>ned by<br>s deta                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Part II. Other significant conditions contributing to                                                       | death but not re                       | sulting in the u                                   | underlying cause gi                      | ven in Part I.                              | 23e. Did tol                      | bacco use contribute t             | o the cause of death?                            |
| Vital Records, | w require<br>been sig<br>should be                                                                                                                                        | ed by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | DEED VENOUS THE                                                                                             | OMBO:                                  | 515                                                |                                          |                                             | 1 □ Y                             | es 2□No 3□P                        | robably 4 Unknown                                |
| ecc            | law re<br>las be                                                                                                                                                          | Completed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | HYPERTENSON                                                                                                 |                                        |                                                    |                                          |                                             | 24a. Was a                        | sv prior to                        | utopsy findings available completion of cause of |
| <u>~</u>       | : The cate h                                                                                                                                                              | Con                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                             | perfor                                 | med? death?<br>2 No 1 ☐ Yes                        |                                          |                                             |                                   |                                    |                                                  |
| K              | siclan<br>certifi<br>rector                                                                                                                                               | 25. Was case referred to medical examiner?  1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                             |                                        |                                                    |                                          |                                             |                                   |                                    |                                                  |
| 0              | g Phy<br>er this<br>eral di                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                             |                                        |                                                    |                                          |                                             |                                   |                                    |                                                  |
| ion            | ath.<br>ath.<br>or: Aft                                                                                                                                                   | 27. Manner of Death  1 Natural  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  M  28c. Injury at Work?  1 Yes 2 No  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Rout City or Town, State) |                                                                                                             |                                        |                                                    |                                          |                                             |                                   |                                    |                                                  |
| Division or    | or Attending Physician: Ifter death. Director: After this certifics in by the funeral director, p                                                                         | rtific                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Plac built                                                     | e of injury - At I<br>ding, etc. (Spec | nome, farm, st                                     | treet, factory, office                   |                                             | 28f. Location (Si<br>City or Town | treet and Number or R<br>n, State) | Tural Route Number,                              |
|                | pital o                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 29a. Certifier 1 Certifying Physician: To the                                                               | ne heet of my kr                       | nowledge dea                                       | th occurred at the t                     | ime date and place                          | and due to the o                  | auca(c) and manner a               | e stated                                         |
|                | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer                                              | Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (Check only 2 Medical Examiner: On the                                                                      | basis of examir<br>nner stated.        | nation and/or in                                   | nvestigation, in my                      | opinion, death occu                         | irred at the time, o              | date and place, and du             | e to the cause(s)                                |
|                | To th<br>within<br>To th<br>comp                                                                                                                                          | Me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 29b. Signature and title of certifier                                                                       |                                        |                                                    | 29c. Licen                               | se number                                   | 2                                 | 9d. Date signed (Mon               | th, Day, Year)                                   |
|                |                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | P. LEDAKIS M                                                                                                |                                        |                                                    | Dy-                                      | 7934                                        | f                                 | BOURLY !                           | 25, 7008                                         |
| j              | 0                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 30. Name and address of person who completed car                                                            | use of death (Ite                      | m 23a) (Type                                       | Print)                                   | HTIMONE                                     | 2 MM 2                            | ואו                                |                                                  |
|                | Sta                                                                                                                                                                       | ite                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 31. Date filed (Month, Day, Year) 32.                                                                       | Registrar's Sign                       | nature                                             |                                          | 701111000                                   |                                   | ,                                  |                                                  |
|                | Regist                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | FEB 2 8 2008                                                                                                | A Book                                 | e de                                               | A made o                                 |                                             |                                   |                                    |                                                  |
| DUI            | 4LI 17 Day 1/0                                                                                                                                                            | 001                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                             |                                        |                                                    | 5                                        |                                             |                                   |                                    |                                                  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 061 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Q26 PM **Physician** Alice Ridgely /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1 □ M 2 🛛 F 96 01-28-1912 Director 216-10-5414 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heathh and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6504 Corkley Rd 21237 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No White ģ Specify: 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Cornwell Katie Mahone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shirlee Wingate (Dtr-In-Law) 6504 Corkley Rd Baltimore, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Gardens of Faith 02-28-2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home of Bel Air Defamo mek Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) tac **Physician** Teen /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as been signed by the attending I should be detached for use as IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II/Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 20 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24a. Was an certificate has I 1□ Yes 2☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 48 Nursing Home 5 Residence 6 Other (Specify) ို 1 🔲 Yes 2/2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Iniury 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) impleted cause of death (Item 23a) (Type, Print) e and a dre 308 31. Date filed (Month, Day, Year) 32. Registrar's Signat State FEB 2 8 2008 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 10:15 A.M. amar ANDLE 02 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner University of Maryland Medical 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ₹M 2 □ F Hours 10 Feb 11, 2008 Maryland none Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Director MD Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number

P.O. Box 68760

**Funeral** 

Director

requires that the death certificate be executed and Records, Division or Vital

Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notifled at 1 ☐ Yes 2 ☐ No 2 Silverton Avenue 21227 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify Specify. black 3 Widowed 4 Divorced Year or Dates Completed er than "natur , the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "r any injury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be Patricia Randle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of Md Med Ctr 22 S. Green Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖾 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Signature of Funeral Roma Id S. Wady, Director 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate C use (Final disease or con lilion resulting in death) rematur **Physician** EXTREME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician ar Is the burial-ti Due to (or as a consequence of): Physician/Medical as the attending partners as the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 02 11 2002 s been signed by the should be detach€ 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an this certificate has ral director, page 2 autopsy performed 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 🙀 Inpatient P After thi funeral of 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Creene STa. BALTIMORE MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

|                                                                                                                                                                                                                                                             |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Pleas                                                                                              | -               |                                            |               |                 |                                          |                                   |                           | •                                         | re Legible.                                 |                                                     |
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|                                                                                                                                                                                                                                                             |                                                                                      | _ R                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | egistrar Amend #8, p                                                                               |                 | g876, 2/2                                  | 8/08 <u>T</u> | T Cei           | unicate of                               | Deam                              | 2 1                       | Reg<br>Date of Death                      | . No. 2                                     | 3. Time of Death                                    |
| Physi<br>/Me                                                                                                                                                                                                                                                |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Serena                                                                                             | -               | 20bins                                     | 00            |                 |                                          |                                   |                           | Month                                     | Day Year 2008                               |                                                     |
| Exam                                                                                                                                                                                                                                                        | nine                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | cility Name (If not institution,                                                                   |                 |                                            |               |                 | 4b. City, Town, o                        |                                   |                           |                                           | 4c. County of Dea                           | th                                                  |
|                                                                                                                                                                                                                                                             | 3                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Inion Memorial Ho                                                                                  | spita<br>6. Sex |                                            | o (In urs     | ast birthday)   | If Under 1 Year                          | Balt<br>If Under 24               | timore                    | Date of Birth                             | o Bir                                       | thplace (State or Foreign                           |
| Funera<br>Directo                                                                                                                                                                                                                                           |                                                                                      | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 219-16-6934                                                                                        |                 | 2[ <b>X</b> F                              | 83            | Yrs.            | Months Days                              |                                   | Min.                      | Date of Birth<br>Month, Day, Y<br>ebruary | <sup>ear)</sup> 1924                        | MD                                                  |
| land<br>w                                                                                                                                                                                                                                                   |                                                                                      | 10a. S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Residence of Decedent state 10b. County                                                            |                 |                                            | 10c. City     | , Town or Lo    | cation                                   |                                   |                           |                                           |                                             | 10d. Inside City Limits                             |
| Mary<br>-f sho<br>fied a                                                                                                                                                                                                                                    | Ì                                                                                    | Į ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1D                                                                                                 |                 |                                            |               | Ba              | ltimore                                  |                                   |                           |                                           |                                             | 1XXYes 2 ☐ No                                       |
| h the<br>or 28a                                                                                                                                                                                                                                             | Director                                                                             | 10e. S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Street and Number                                                                                  |                 |                                            |               |                 | 10f. Zip Code                            |                                   |                           | 100                                       | g. Citizen of What Co                       | ountry?                                             |
| th wit<br>23a c<br>1st be                                                                                                                                                                                                                                   | -                                                                                    | 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 3458 Caton Avenue                                                                                  | : (We           | est)                                       |               |                 | 2.                                       | 1229                              |                           |                                           | USA                                         |                                                     |
| r dea                                                                                                                                                                                                                                                       | Granda                                                                               | 11. M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | arital Status                                                                                      |                 | Was Decedent<br>Armed Forces?              |               | S. 13.1         | Was Decedent of H<br>If Yes, specify Cub | lispanic Origin<br>an, Mexican, P | ? (Specify<br>Puerto Rica | Yes or No-<br>in, etc.)                   | 14. Race - Ame<br>Black, Whi                |                                                     |
| 'e, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland Health and Mential Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Examiner must be notifiled at | 1                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | □Never Married 2□ Marrie<br>□Widowed 4□Divorced                                                    | ed              | 1 ☐ Yes 2 1 If Yes, Give<br>Year or Dates: | No            |                 | 1 ☐ Yes 2 🕱 No                           | Specify:                          |                           |                                           | Specify:                                    | Black                                               |
| Maryland 21215-0036 nd 2 should be filed within 72 hours af tith and Mental Hygiene. 27 is marked other than "natural"; or traumatic event, the Medical Exami                                                                                               | 7                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 15. Decedent'                                                                                      |                 | ion                                        |               | 16a. Dece       | dent's Usual Occup                       | pation                            |                           | 16                                        | 6b. Kind of Business                        | /industry                                           |
| 215<br>Pin 73<br>Pin 73<br>Pin 74<br>Aledi                                                                                                                                                                                                                  | 100                                                                                  | Ele                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (Specify only highest<br>mentary/Secondary (0-12)                                                  | grade c         | Ompleted) College (1-4or 5                 | 5+)           | (Give<br>life.  | kind of work done<br>DO NOT use retired  | during most of<br>d)              | t working                 | - 1                                       |                                             |                                                     |
| 21<br>ad with                                                                                                                                                                                                                                               | Completed                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 12                                                                                                 |                 |                                            | ,             |                 | domes                                    |                                   |                           |                                           | homemake                                    | er                                                  |
| be file                                                                                                                                                                                                                                                     | 8                                                                                    | 17. Fa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ther's Name (First, Middle, L                                                                      | . 1             |                                            |               |                 |                                          | 18. Mother's                      | Name (Fi                  | rst, Middle, Ma                           | aiden Surname)                              |                                                     |
| aryla<br>should I<br>and Men<br>s marke<br>umatic                                                                                                                                                                                                           | 15                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    | iam F           |                                            |               | 405 14-00       | - Add /C44                               |                                   |                           | ude Figg                                  | City or Town, State,                        | Zin Code)                                           |
| Mal<br>d2st<br>th and<br>th and<br>T is n                                                                                                                                                                                                                   |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Informant's Name/Relationsh<br>Shawn R. Harby /                                                    |                 | *                                          |               |                 | G. Conkling                              |                                   |                           | ,                                         | , ,                                         | zip Code)                                           |
| iore, N<br>ges 1 and<br>it of Health<br>if item 27<br>or other to                                                                                                                                                                                           | 1                                                                                    | - X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Method of Disposition                                                                              |                 |                                            | 20b. P        | lace of Dispo   | sition (Name of                          | 1                                 | Date                      |                                           | Oc. Location - City or                      | Town, State                                         |
| Pages<br>nent of<br>int: If its                                                                                                                                                                                                                             |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | X Burial 2 ☐ Cremation ☐ Donation 5 ☐ Other (Sp                                                    |                 | noval from State                           |               |                 | matorý or other pla:<br>Forest Vet       | i i                               | 3/05/2                    | 008                                       | wings Mills.                                | Mary land                                           |
| Baltimore, permit. Pages 1 ar Department of Hea Important: if item any injury or other                                                                                                                                                                      | نو                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ignature of Funeral Service L                                                                      |                 |                                            |               |                 | 2. Name and Addre                        |                                   |                           |                                           | 1 Home, P.A.                                |                                                     |
| m Feff                                                                                                                                                                                                                                                      | OSO III GLIMI SCIECCI, PATCHISTO, IN HILLI                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |                 |                                            |               |                 |                                          |                                   |                           |                                           |                                             |                                                     |
|                                                                                                                                                                                                                                                             |                                                                                      | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                    |                 |                                            |               |                 |                                          |                                   |                           |                                           |                                             | Approximate<br>Interval Between                     |
| Physicia                                                                                                                                                                                                                                                    |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |                 |                                            |               |                 |                                          |                                   |                           |                                           |                                             | Onset and Death                                     |
| / /Medica<br>Examine                                                                                                                                                                                                                                        | _                                                                                    | resulting in death)  Due to (or as a consequence of):  Sequentially list conditions  Due to (or as a consequence of):  Univery Tract Infection  University of the conditions o |                                                                                                    |                 |                                            |               |                 |                                          |                                   |                           |                                           |                                             |                                                     |
| Examine                                                                                                                                                                                                                                                     |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |                 |                                            |               |                 |                                          |                                   |                           |                                           | Unterown                                    |                                                     |
| rted<br>nsit                                                                                                                                                                                                                                                | - Andrews                                                                            | cause                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | entially list conditions,<br>, leading to immediate<br>e. Enter Underlying<br>e (Disease or injury |                 | R Dass                                     | +             | Can             | 2                                        |                                   |                           |                                           |                                             | Unknown                                             |
| 760, be executed sician and burial-transit                                                                                                                                                                                                                  | 2                                                                                    | result                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | nitiated events<br>ing in death) Last                                                              | c               | Due to (or as                              | a consequ     |                 |                                          |                                   |                           |                                           |                                             |                                                     |
| 176<br>Ite be<br>lysicia<br>ne bur                                                                                                                                                                                                                          | 2                                                                                    | 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                    | d               |                                            |               |                 |                                          |                                   |                           |                                           |                                             |                                                     |
| c 687<br>ertificate<br>ing phys                                                                                                                                                                                                                             | No.                                                                                  | IF FF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | MALE:                                                                                              |                 |                                            |               |                 |                                          | · -                               |                           |                                           |                                             |                                                     |
| Box 687( death certificate be attending physic                                                                                                                                                                                                              | , no                                                                                 | 23b.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Was decedent pregnant in the past 12 months?                                                       | 230             | If yes, outcome<br>1☐Live birth            | 2 ☐ Feta      | I death 3       | Ectopic pregnanc                         | у                                 |                           |                                           | 23d. Date of de<br>Month                    | elivery<br>Day Year                                 |
| I Records, P.O. Box 687  The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the                                                                                                      | Dhysician (Madical                                                                   | 25                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1  Yes 2  No<br>9  Unknown                                                                         |                 | 4□Pregnant a<br>9□Unknown                  | t time of d   | eath 5L         | Other (specify) _                        |                                   |                           |                                           |                                             |                                                     |
| that the ed by detac                                                                                                                                                                                                                                        |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | . Other significant conditio                                                                       | ns contri       | buting to death b                          | ut not res    | ulting in the u | nderlying cause giv                      | ven in Part I.                    |                           | 23e. Did toba                             | acco use contribute                         | to the cause of death?                              |
| Vital Records, P.O. sician: The law requires that the di certificate has been signed by the rector, page 2 should be detached                                                                                                                               | 1                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |                 |                                            |               |                 |                                          |                                   |                           | 1 ☐ Yes                                   | 2 □ No 3 □ F                                | robably 4 JUnknown                                  |
| aw red                                                                                                                                                                                                                                                      | 100                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |                 |                                            |               |                 |                                          |                                   |                           | 24a. Was an                               | 24b. Were a                                 | utopsy findings available<br>completion of cause of |
|                                                                                                                                                                                                                                                             | 8                                                                                    | 24a. Was an autopsy performed performed to the second seco |                                                                                                    |                 |                                            |               |                 |                                          |                                   |                           |                                           |                                             |                                                     |
| /ita                                                                                                                                                                                                                                                        | 8                                                                                    | 25. Was case referred to medical 26. Place of Death (Check only one)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                    |                 |                                            |               |                 |                                          |                                   |                           |                                           |                                             |                                                     |
| or V<br>hysic<br>this o                                                                                                                                                                                                                                     | F                                                                                    | 1   Yes 2   No   Hospital: + Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                    |                 |                                            |               |                 |                                          |                                   |                           |                                           |                                             |                                                     |
| Division or I or Attending Physicater death.  Director: After this in by the funeral di                                                                                                                                                                     | 2                                                                                    | 27. Manng-of Death 28a. Date of Injury 1 Phatural 5 Pending (Month, Day Year)   Month, Da |                                                                                                    |                 |                                            |               |                 |                                          |                                   |                           |                                           |                                             |                                                     |
| or Attending I<br>after death.<br>Director: After<br>in by the funer                                                                                                                                                                                        | 100                                                                                  | 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                    |                 |                                            |               |                 |                                          |                                   |                           | Rural Route Number.                       |                                             |                                                     |
| Div<br>after<br>I Dire                                                                                                                                                                                                                                      | 1                                                                                    | 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Homicide determi                                                                                   | ned             | building, et                               | tc. (Specif   | (y)             | •                                        |                                   |                           | City or Town,                             |                                             |                                                     |
| Division or Vita  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, i                                                                       | ) legipo                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (Check only 2 Medical I                                                                            | g Physic        | ian: To the best<br>r: On the basis o      | of my kno     | wledge, deal    | th occurred at the ti                    | ime, date and popinion, death     | place, and                | due to the ca                             | use(s) and manner a<br>te and place, and du | as stated. ue to the cause(s)                       |
| To the Ivithin 24<br>To the F                                                                                                                                                                                                                               | Modi                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | one) Signature and title of certifier                                                              |                 | and manner st                              |               |                 | 29c. Licens                              |                                   |                           |                                           | d. Date signed (Mor                         |                                                     |
| N N N N N N N N N N N N N N N N N N N                                                                                                                                                                                                                       | ATZ438946 HZ Feb 27, 2008                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |                 |                                            |               |                 |                                          |                                   |                           |                                           |                                             |                                                     |
| 1                                                                                                                                                                                                                                                           | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |                 |                                            |               |                 |                                          | .,000                             |                           |                                           |                                             |                                                     |
| 9                                                                                                                                                                                                                                                           |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Matthew                                                                                            |                 | san, P                                     | 0.0           | - (             | Jaron 1                                  | Mensio                            | H L                       | -uspital                                  | MD                                          |                                                     |
|                                                                                                                                                                                                                                                             | State                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ate filed (Month, Day, Year)                                                                       | 0.00            | 32. Radisti                                | rar's Signa   | ature           | land .                                   |                                   |                           | •                                         |                                             |                                                     |
| Regi                                                                                                                                                                                                                                                        |                                                                                      | _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | FEB 2 8 2008 A Server A A Server                                                                   |                 |                                            |               |                 |                                          |                                   |                           |                                           |                                             |                                                     |

|            |                                                                                                                                                                                                                                                                                                    | 1                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | epartment of Health and M<br>Ce <i>rtificate of Death</i>                                                   | ental Hygiene<br>Reg. No                            | 000 0012                                                                    |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------------------------|
|            | Physicia                                                                                                                                                                                                                                                                                           |                     | Decedent's Name (First, Middle, Last)  LUCILLE C. REE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | CER                                                                                                         | 2. Date of Death<br>Month Da                        | 3. Time of Death                                                            |
|            | /Medic                                                                                                                                                                                                                                                                                             | al -                | ia. Facility Name (If not institution, give street and number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4b. City, Town, or Location of Death                                                                        | FEBRUARY                                            | 25,2008 11:05Å<br>:: County of Death                                        |
| E          | Examin                                                                                                                                                                                                                                                                                             | er                  | FRANKLIN WOODS NURSING HOME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                             |                                                     | BALTIMORE                                                                   |
|            | Funeral<br>Director                                                                                                                                                                                                                                                                                |                     | 219-10-0845                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | nday) If Under 1 Year if Under 24 Hrs. Months Days Hours Min.                                               | 8. Date of Birth (Month, Day, Year, 9 – 9 – 1 9 2 2 | 9. Birthplace (State or Foreign Country) MARYLAND                           |
|            | Maryland<br>1 ahow<br>1ed at                                                                                                                                                                                                                                                                       |                     | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town 10b. BALTIMORE 10c. City, Town                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | or Location ROSEDALE                                                                                        |                                                     | 10d. Inside City Limits<br>1 ☐ Yes ※XXNo                                    |
|            | 3a or 28a-                                                                                                                                                                                                                                                                                         | i Direct            | 10e. Street and Number<br>8411 ROCKY MT ROAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 10f. Zip Code 21237                                                                                         | 10g. C                                              | itizen of What Country? U.S.A.                                              |
| 36         | parmit. Pages 1 and 2 should be filad within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 ahow any injury or other traumatic evant, the Madical Evant and must be notified at once. | by Funeral Director | 11. Marital Status  1 □ Never Married 2 □ Married  3 ▼Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ▼ No  If Yes, Give  Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 13. Was Decedent of Hispanic Origin? (Spulf Yes, specify Cuban, Mexican, Puerto                             | ecify Yes or No-<br>Rican, etc.)                    | 14. Race - American Indian, Black, White, etc.  Specify: WHITE              |
| 21215-0036 | thin 72 hou<br>le.<br>len "nature<br>Medical E                                                                                                                                                                                                                                                     | Completed           | ••                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  WAITRESS | ing                                                 | Kind of Business/Industry  RESTAURANT                                       |
| 121        | ilad wi<br>Hygien<br>ther th                                                                                                                                                                                                                                                                       |                     | 8<br>17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                             | e (First, Middle, Maide                             |                                                                             |
| anc        | id be fi<br>ental I<br>ked ot<br>ic eval                                                                                                                                                                                                                                                           | To Be               | WILLIAM STRAPPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                             |                                                     | (UNKNOWN)                                                                   |
| Maryland   | 2 shou<br>and M<br>is mar<br>aumat                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Mailing Address (Street and Number or Rura<br>007 MAIDBROOK ROA                                             |                                                     | or Town, State, Zip Code)                                                   |
| e, ≥       | 1 and<br>Health<br>em 27<br>ther tr                                                                                                                                                                                                                                                                |                     | 20b. Place of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Disposition (Name of                                                                                        |                                                     | Location - City or Town, State                                              |
| mor        | Pages<br>ent of<br>nt: If it                                                                                                                                                                                                                                                                       |                     | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | y, crematory or other place) CNS OF FAITH 2-29                                                              | 9-08 BA                                             | LTIMORE, MD                                                                 |
| Baltimore, | parmit. Departm Importa any inju                                                                                                                                                                                                                                                                   |                     | 21. Signature of Funeral Service Licensee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 22. Name and Address of Facility CVA 1211 CHESACO AVI                                                       | ACH/ROSED                                           | DALE FUNERAL HOME<br>CDALE, MD 21237                                        |
|            |                                                                                                                                                                                                                                                                                                    |                     | 23a. Partition the disease or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | not enter the mode of dying, such as cardiac                                                                | or respiratory arrest,                              | Approximate<br>Interval Between<br>Onset and Death                          |
|            | Pnysician<br>/Medical                                                                                                                                                                                                                                                                              |                     | Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of the condition of the condi | Dementia                                                                                                    |                                                     |                                                                             |
|            | Examiner                                                                                                                                                                                                                                                                                           | Jer                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | of):                                                                                                        |                                                     |                                                                             |
| •          | cate be executed<br>physician and<br>the burial-transit                                                                                                                                                                                                                                            | Examin              | Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or conseque | of):                                                                                                        |                                                     |                                                                             |
| 68760,     | cate be e<br>physiciar<br>the buri                                                                                                                                                                                                                                                                 | dicai E             | C d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                             |                                                     |                                                                             |
| O. Box 68  | death certifi<br>e attending  <br>id for use as                                                                                                                                                                                                                                                    | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 No 9 □ Unknown  1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 3 ☐ Ectopic pregnancy<br>5 ☐ Other (specify)                                                                |                                                     | 23d. Date of delivery<br>Month Day Year                                     |
| s, P.      | uiras that the signed by d be detacted                                                                                                                                                                                                                                                             | by                  | Part II. Other significant conditions contributing to death but not resulting in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | n the underlying cause given in Part I.                                                                     |                                                     | o use contribute to the cause of death?<br>2 No 3 Probably 4 Unknown        |
| Record     | The law raquiras that the rate has been signed by the page 2 should be detache                                                                                                                                                                                                                     | Completed           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                             | 24a. Was an autopsy performed?                      | 24b. Were autopsy findings available prior to completion of cause of death? |
| Vital      |                                                                                                                                                                                                                                                                                                    | Be C                | 25. Was case referred to medical examiner?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                             | th Check on one                                     |                                                                             |
| of V       | hys<br>his                                                                                                                                                                                                                                                                                         | 2                   | 1 ☐ Yes 2 ☐ HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/OL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                             | ome 5 Residence<br>28d. Describe how in             | 6 ☐ Other (Specify)  njury occurred                                         |
|            | on (fter                                                                                                                                                                                                                                                                                           | ation               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Time of njury at Work?  M 1 \[ Yes 2 \] No                                                                  |                                                     |                                                                             |
| Division   | - 9                                                                                                                                                                                                                                                                                                | Certification;      | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, Is building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | arm, street, factory, office                                                                                | 28f. Location (Street<br>City or Town, Sta          | and Number or Rural Route Number,<br>ate)                                   |
|            | To the Hospital o within 24 hours aft To the Funeral D completely filled in                                                                                                                                                                                                                        | Medicai C           | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledg 2 Medicel Exeminer: On the basis of examination are and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | e, death occurred at the time, date and place ad/or investigation, in my opinion, death occu                | and due to the cause<br>rred at the time, date a    | e(s) and manner as stated.<br>and place, and due to the cause(s)            |
| )          | To th<br>within<br>To th<br>compl                                                                                                                                                                                                                                                                  | Me                  | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 29c. License number                                                                                         |                                                     | Date signed (Month, Day, Year)  bruch 25, 2008                              |
| C          | 4                                                                                                                                                                                                                                                                                                  |                     | 30. Name and address of person who completed cause of death (Item 23a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ^ ~ /                                                                                                       | la Himno                                            | MD 21237                                                                    |
| 7          | St                                                                                                                                                                                                                                                                                                 | ate                 | Tom Edmondson 9/05 Franklin Sun 31. Date filed (Month, Day, Year) 32. Registrar's Gignature FR 2 8 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | and of the state of                                                                                         | at Him of C                                         |                                                                             |
|            | Regist                                                                                                                                                                                                                                                                                             | rar                 | LERY O TOOL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                             |                                                     |                                                                             |

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Rosen 4:050 /Medical Wil Bent 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Has A. Kol 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 X M 2 □ F Hours 220-36-9783 Director 05/27/1941 66 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health, and Mental Hygiene. Inraportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eximiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits 2 should be more and Mental Hygiene.
I sam Mental Hygiene.
I is marked other than "natural", or Items 23a or 20er.
I is marked other than Medical Eximiner must be notified at Completed by Funeral Director 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 OLD COURT ROAD, #618 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 💢 No Specify. Specify: 3 Widowed 4 Divorced WHITE Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 SALES SUN GLASSES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROSENBAUM IDA ROSENBLOOM ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAURICE OFFIT / ATTORNEY 8171 MAPLE LAWN BLVD., #200, MAPLE LAWN, MD 20759 20b. Place of Disposition (Name of ANSHE EMUNAH 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ATTZ CHAIM CONG. 02/26/2008 | BALTIMORE, MD 21. Signature of uneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Gostro in tastinul /Medical Due to (or as a consequence of): Examiner Controllug Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last AOD-Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed L bra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Respiratory ra. lune Were autopsy findings available prior to completion of cause of 24a. Was an Corner autopsy performed' certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 phypatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director; / 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completely filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 D2903 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401

DHMH 17 Rev 1/2001

Registrar

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FEB 2 8 2008

31. Date filed (Month, Day, Year)

2. Registrar's Signature

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Court

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle\_Last) Day 25 **Physician** 2008 LOBINSON ChryAn h (51 /Medical own, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner AI And Alls to catherest 610170 If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 02/01/1916 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 € F NY 92 089-14-5477 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e, Street and Number 10f. Zin Code 3615 FORDS LANE, #318 21215 USA Funeral Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 3 □ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 should be filed w h and Mental Hygieu 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 is marked only Injury or other traumatic events. DERMER SIGMUND ROBINSON SARAH 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5237 N.W. 22ND AVENUE, BOCA RATON, FL 33496 SIGMUND HABER / NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BETH\_ISRAEL\_CEMETERY 02/27/2008 WOODBRIDGE, NJ 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-transit and / Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 menths? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknows 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 21X No 1 ☐ Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 [ Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Tyes this 27. Manner of Deat 28a Date of Injury 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b nature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

2008

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nd address of person who completed cause of death (Item 23a) (Type, Print)

019

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JAMES FRANKLIN ROSS /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner MOI N/A Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Director 8-18-1940 VIRGINIA 227-50-3856 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 No Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA by Funeral 1664 CLIFTVIEW AVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Droptant: If them 27 is marked other than "ratuu any Injury or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maryland 212 TRANSPORTATION BUSINESS OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUISE TAYLOR ဂ္ CHARLIE ROSS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3815 FORRESTER AVE. BALTIMORE, MARYLAND 21206 GARY ROSS (SON) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Crematio 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-1-2008 BALTIMORE, MARYLAND KING MEMORIAL PARK 21. Signature of Juneral Service HIBNER Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Egler the disease, or complications that caused the death. Do not enter the heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to himsulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit The law requires that the death certificate be executed A PE Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy signed by the atter Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9∏Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No certificate has been si rector, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an perform or Attending Physician; 25. Was case referred examiner? 26. Place of Death (Check only one) 2 NO Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 □ R/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) . Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director; / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral C completely filled i Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signati who completed couse of death (Item 23a) (Type, Print)

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Registrar

31. Date filed (Month, Day,

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JOHNS MOPKINS BAYVIEW MEDICAL CENTER, BALTIMORE, MO, 21224

FEBRUARY 25

BM BCL.

32. Registrar's Signature

Contract of the second

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OF CHRISTOPHER HOURIGAN,

Year)

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31. Date filed (Month, Day, FEB 2

Registrar

State

Jude Miners

FEB

31. Date filed (Month, Day, Year)

DAKWOOD

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32. Registrat's Signature

Glen Burnie

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygien ? 0620 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Feb. **Physician** TINDALL 2008 WINIFRED SHARPE 3:00 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 369 Homeland Southway Apt. 2 A Baltimore n/a If Under 1 Year | If Under 24 Hrs. 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 □ M 2 👽 F Yrs. 416-24-2794 86 11, Director 1921 Alabama Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 11√2 Yes 2 □ No Director Maryland N/A**Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21212 369 Homeland Southway Apt. 2 A U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 2 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medicone. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Elmer Jackson Tindal1 Helen Sanders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Freeman (son-inlaw) 5301 Springlake Way Baltimore, Maryland Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 2-28-08 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 Mitchell-Wiedefeld F.H. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years **Physician** Colon Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year Month 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 21 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1∐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: 1 ☐ Yes 2 7 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA မှ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tiff Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person

31. Date filed (Month, Day,

W. Huns

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Year)

8 2008

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who completed cause of death (Item 23a) (Type, Print)

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32 Registrar's Signature

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 2008 OTHA RHENONT STEVENS County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death May raber Prince 900 00, 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Months Days Hours 79<sup>Yrs</sup> 260-44-9900 JUNE 27, 1928 North Carolina Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Prince George's Upper Malboro 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 900 Faber Place USA 20774 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 2yrs. Barber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Percy Stevens Minnie Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rubve Stevens/wife 900 Faber Place, Upper Marlboro, Maryland 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ↑ Removal from State 4 Donation 5 Other (Specify) Maryland Veteran Cem. 3-3-2008 Cheltenham, Maryland 21. Signature of Funeral Se 22. Name and Address of Facility Marshall's Funeral Home of MD D. GRAY 4308 Suitland Road, Suitland, Maryland 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypertensive Heart Disea Arterioscheotic Due to (or as a consequence of) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for self-rennesquence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an autopsy performe 1∐ Yes 2 No

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral Director** 

Completed by

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MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be marked.

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division or Vital Records,

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Examiner

Physician/Medical

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Certification:

Medical

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requires that the death certificate be executed Physician: Hospital or Attending n 24 hours after death.

ne Funeral Director; A

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Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 Hos SALVAdor

31. Date filed (Month, Day,

25. Was case referred to medical

Registrar

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Joseph Frank Sandy 2008 3:00 AM<sup>M</sup> Feb. 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 86 1922 201-01-8234 Feb. 13 **Director** Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any intro-yor other traumatic event, the Medical Examiner must be notified at any intro-yor other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 ☐ Yes 2X No Cockeysville Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21030 607 Cranbrook Rd. Apt. D USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 🏖 No white Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Pipe Fitter Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Andrew Sandy Rose Furin ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Sandy/wife 607 Cranbrook Rd. Apt. D, Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 Deremation 3 R 4 Donation 5 Dether (Specify) 2/25/08 3 ☐Removal from State Dulaney Valley Memorial Gardens Timonium, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 Fundur of Fundral Service Licenses Lowell M. Lemmon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): esser Physician ecade. /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be execute Due to (or as a consequence of): P.O. Box 68760, physician a Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown is certificate has been signed director, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OIGe Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. the To the 29c. License number 29b. Signature and title of certifier th (Item 23a) (Type, Print) 30. Name and address of person who completed cause of dea 6701 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar 3 Registrar's Signature

|                                                                                                                                                                                                                                                                                                                                    |                        | 1 - For<br>State<br>Registrar Amend #27,                                                                                          | nerME o877 3/10/0                                                                      | ina/be <br>12 mr <i>C</i> ∈ | ertificate of                                                  | ieaith and iv<br>Death | ientai Hygie<br><sub>Reg.</sub>      | - Z I I I I K               | 06205                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------|------------------------|--------------------------------------|-----------------------------|-----------------------------------------------|
| DI11                                                                                                                                                                                                                                                                                                                               | O                      | Decedent's Name (First, Middle, Language)                                                                                         | ast)                                                                                   | <i>N</i> 11                 |                                                                |                        | 2. Date of Death<br>Month            |                             | 3. Time of Death                              |
| Physici<br>/Medic                                                                                                                                                                                                                                                                                                                  |                        |                                                                                                                                   | Earl R.                                                                                | Sch1                        | issler                                                         |                        | Feb                                  | 23 2008                     |                                               |
| Examir                                                                                                                                                                                                                                                                                                                             | er                     | 4a. Facility Name (If not institution, gi                                                                                         |                                                                                        | more                        |                                                                | Location of Death      |                                      | 4c. County of Death         |                                               |
| Funeral                                                                                                                                                                                                                                                                                                                            |                        |                                                                                                                                   |                                                                                        | s. last birthda             | y) If Under 1 Year                                             | If Under 24 Hrs.       | 8. Date of Birth                     | N/A<br>9. Birth             | place (State or Foreign                       |
| Director                                                                                                                                                                                                                                                                                                                           |                        | 219-03-4129 Usual Residence of Decedent                                                                                           | 1X M 2□F 87                                                                            | Yrs.                        | Months Days                                                    | Hours Min.             | Feb. 13,                             | 1921 M                      | place (State or Foreign<br>intry)<br>aryland  |
| yland<br>now<br>at                                                                                                                                                                                                                                                                                                                 |                        | 10a. State 10b. County                                                                                                            | 10c.                                                                                   | City, Town or               | Location                                                       |                        |                                      |                             | 10d. Inside City Limits                       |
| e Mar<br>la-f st<br>tifled                                                                                                                                                                                                                                                                                                         | ctor                   | Maryland Anne Ar                                                                                                                  | undel                                                                                  | Arnol                       | d                                                              |                        |                                      |                             | 1 □Yes 2 戊No                                  |
| vith th                                                                                                                                                                                                                                                                                                                            | Director               | 10e. Street and Number                                                                                                            |                                                                                        |                             | 10f. Zip Code                                                  | ^                      | 10g.                                 | . Citizen of What Cou       | ntry?                                         |
| eath v                                                                                                                                                                                                                                                                                                                             | Funeral                | 977 Bayberry D                                                                                                                    | Jr1ve<br>12. Was Decedent Ever in                                                      | U.S. 13                     | 2101<br>3. Was Decedent of H                                   |                        | ecify Yes or No-                     | U.S.A.                      | can Indian.                                   |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.                                  | þ                      | 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced                                                                            | Armed Forces?  1 Wes 2 No If Yes, Give 1944- Year or Dates:                            | 1946                        | 3. Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 ☐ No | Specify:               | Rican, etc.)                         | Black, White,               |                                               |
| 72 hou<br>natura<br>lical E                                                                                                                                                                                                                                                                                                        | ted                    | 15. Decedent's E<br>(Specify only highest gr                                                                                      | ducation                                                                               | 16a. Dec                    | cedent's Usual Occup                                           | ation                  | 161                                  | b. Kind of Business/Ir      |                                               |
| ithin 7<br>ne.<br>nan "r                                                                                                                                                                                                                                                                                                           | Completed              | Elementary/Secondary (0-12)                                                                                                       | College (1-4or 5+)                                                                     | life                        | ve kind of work done of DO NOT use retired                     | 1                      |                                      | C+ . T                      | <b></b>                                       |
| Hygiel<br>Hygiel<br>Iher th                                                                                                                                                                                                                                                                                                        | S                      | 17. Father's Name (First, Middle, Las                                                                                             | 4                                                                                      |                             | <u>Eng</u>                                                     | ineer                  | A1<br>e (First, Middle, Mai          | rcraft In                   | austry                                        |
| d be f<br>ental I<br>ked of                                                                                                                                                                                                                                                                                                        | To Be                  | Earl                                                                                                                              | *                                                                                      | lissle                      | r                                                              |                        | lise                                 | Jones                       |                                               |
| shoul<br>and Mark<br>mark                                                                                                                                                                                                                                                                                                          | ř                      | 19a. Informant's Name/Relationship                                                                                                |                                                                                        |                             |                                                                |                        |                                      | ity or Town, State, Zi      | p Code) 21078                                 |
| and 2<br>saith a<br>n 27 ls                                                                                                                                                                                                                                                                                                        |                        | Raymond E. Schlis                                                                                                                 |                                                                                        |                             |                                                                |                        | Havre D                              | e Grace, l                  | Maryland                                      |
| ges 1<br>t of He<br>If iten<br>or oth                                                                                                                                                                                                                                                                                              |                        | 20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 [                                                                          | 20b<br>⊒Removal from State                                                             |                             | position (Name of<br>rematory or other plac                    |                        |                                      | c. Location - City or T     |                                               |
| t. Partmen<br>rtant:                                                                                                                                                                                                                                                                                                               |                        | 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci                                                                                  |                                                                                        | illtop                      | Service C                                                      |                        |                                      | -                           | aryland                                       |
| permi<br>Depar<br>Impo<br>any Ir<br>once,                                                                                                                                                                                                                                                                                          |                        | 21. Signature Fun ral 1 ryice Lice                                                                                                | ansee                                                                                  |                             | 22. Name and Address 1050 York                                 | INU.                   |                                      | Funeral aryland 21          |                                               |
|                                                                                                                                                                                                                                                                                                                                    |                        | 23a. Part1. Enter the disease, or conshock, or heart failure. List only                                                           |                                                                                        | ath. Do not e               |                                                                |                        |                                      |                             | Approximate<br>Interval Between               |
| Physician                                                                                                                                                                                                                                                                                                                          | P. 1                   | Immediate Cause (Final disease or condition                                                                                       |                                                                                        | acvar                       |                                                                | remonh                 |                                      |                             | Onset and Death                               |
| /Medical<br>Examiner                                                                                                                                                                                                                                                                                                               |                        | resulting in death)                                                                                                               | Due to (or as a cons                                                                   |                             |                                                                |                        | 0                                    |                             | 4 acres                                       |
| · .                                                                                                                                                                                                                                                                                                                                | <u>-</u>               | Sequentially list conditions,                                                                                                     | b. Due to (or de a come                                                                | amusens offe                |                                                                |                        | -                                    | 11/                         |                                               |
| uted<br>1<br>ansit                                                                                                                                                                                                                                                                                                                 | Examiner               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | 245 10 (01 45 4 50110                                                                  | 0440.00                     |                                                                | 7                      | 1                                    | Y MEDICAL EXAMINER          |                                               |
| exect<br>an and<br>rial-tra                                                                                                                                                                                                                                                                                                        |                        | resulting in death) Last                                                                                                          | C. Due to (or as a cons                                                                | equence of):                |                                                                |                        | APPROVED B                           | MEDICAL                     |                                               |
| ate be<br>hysicii<br>he bu                                                                                                                                                                                                                                                                                                         | edical                 |                                                                                                                                   | d                                                                                      |                             |                                                                | CERTIF                 | ICA                                  |                             |                                               |
| ertificating plans to as t                                                                                                                                                                                                                                                                                                         |                        | IF FEMALE:                                                                                                                        | 000 16 400 04400 00 06 000                                                             |                             |                                                                |                        | •                                    |                             |                                               |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/N            | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                                                      | 23c. If yes, outcome pf preg<br>1 Live birth 2 Fe<br>4 Pregnant at time o<br>9 Unknown | etal death 3                | B Ectopic pregnancy Council Other (specify)                    |                        |                                      | 23d. Date of deliv<br>Month | rery<br>Day Year                              |
| s that<br>ned by                                                                                                                                                                                                                                                                                                                   | by Ph                  | Part II. Other significant conditions                                                                                             | contributing to death but not r                                                        | co use contribute to t      | the cause of death?                                            |                        |                                      |                             |                                               |
| equire<br>en sig                                                                                                                                                                                                                                                                                                                   | ed b                   | Prostate                                                                                                                          | cancer                                                                                 |                             | 1 ☐ Yes                                                        | 2No 3□ Pro             | bably 4 □Unknown                     |                             |                                               |
| law re<br>ras ber<br>e 2 sho                                                                                                                                                                                                                                                                                                       | Completed              |                                                                                                                                   |                                                                                        |                             |                                                                |                        | 24a. Was an autopsy                  | prior to co                 | opsy findings available ompletion of cause of |
| n: The<br>icate l                                                                                                                                                                                                                                                                                                                  |                        |                                                                                                                                   |                                                                                        |                             |                                                                |                        | performe<br>1 Yes 2                  | death?<br>No 1 ☐ Yes        | 2 No                                          |
| siclar<br>certif                                                                                                                                                                                                                                                                                                                   | o Be                   | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No                                                                           | Hospital: 1 Inpatient 2                                                                | □ EB/Outpoti                | ent 3 DOA Oth                                                  |                        | h (Check only one)                   | a Clair 10                  |                                               |
| g Phy<br>er this<br>eral d                                                                                                                                                                                                                                                                                                         | -                      | 27. Manner of Death                                                                                                               | 28a. Date of Injury                                                                    | 28b. Time                   | of 28c. Injur                                                  | 4 Li Nursing Fio       | me 5 ☐ Hesidenc<br>28d. Describe how | e 6 Other (Speci            | <u>(y)</u>                                    |
| ath.<br>r: Aft                                                                                                                                                                                                                                                                                                                     | atio                   | 2 Accident 5 Pending investigation                                                                                                | O/ILIIUA -                                                                             | UNKNO                       |                                                                | Yes 2 No               | fall for                             | om standi                   | nez                                           |
| or Atterde                                                                                                                                                                                                                                                                                                                         | rific                  | 3 ☐ Suicide 6 ☐ Could not be determined                                                                                           | DE 200 Di no of injuny At                                                              | home, farm,                 |                                                                |                        |                                      | et and Number or Run        |                                               |
| pital c                                                                                                                                                                                                                                                                                                                            | Medical Certification: | 29a. Certifier Certifying P                                                                                                       | hysician: To the best of the                                                           | nome                        | ath coourned at the tim                                        |                        | 2525 Bt.                             | Spring Rd L                 | othervike, Mo                                 |
| e Hos<br>24 hc<br>e Fun<br>letely                                                                                                                                                                                                                                                                                                  | dica                   |                                                                                                                                   | iminer: On the basis of exami<br>and manner stated.                                    |                             |                                                                |                        |                                      |                             |                                               |
| To the within To the compl                                                                                                                                                                                                                                                                                                         | Me                     | 29b. Signature and title of certifier                                                                                             |                                                                                        |                             | 29c. License                                                   | e number               | 29d.                                 | . Date signed (Month,       | Day, Year)                                    |
|                                                                                                                                                                                                                                                                                                                                    |                        | MM                                                                                                                                | _                                                                                      |                             | 157                                                            | 794                    | Fei                                  | bnieny:                     | 23,2008                                       |
| 15*1                                                                                                                                                                                                                                                                                                                               |                        | 30. Name and address of person who Pranima No.                                                                                    | completed cause of death (It                                                           | em 23a) (Type               | e, Print)                                                      | of Bo                  |                                      |                             |                                               |
| Sta                                                                                                                                                                                                                                                                                                                                | te                     | 31. Date filed (Month, Day, Year)                                                                                                 | 32. Registrar's Sig                                                                    | nature                      | Parall 2                                                       |                        | ,,,,,,,,                             |                             | x MD 21215                                    |
| Registr                                                                                                                                                                                                                                                                                                                            | ar                     | FEB 2 8                                                                                                                           | ZUUO ASSISSIONE                                                                        | AS P                        | and the second                                                 |                        |                                      |                             |                                               |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 4:16PM Charles Raymond Slater February 26 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Hospital Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months 65 Director 212-42-5166 Aug.11, 1942 Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🏖 ☐ No Director Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21154 USA 1220 Trappe Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. IMYes 2□No
If Yes, Give
Year or Dates: Viet Nam 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🔀 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Terminal Technican 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Leonard В. Slater Marie Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trat once. Darlene M. Slater / WIfe 1220 Trappe Road Street, Maryland 21154 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State Lorraine Park Cem. 2/29/08 Woodlawn, Maryland 21. Signature of Funeral Service Lice isee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Ing. 23a. Part1. Enter the disease, or a implications to claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the each line. Ruck Towson Funeral Home, Inc. Towson, Md. 21204 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) reuton /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that initiated events Due to (or as a consequence of): Physician/Medical Examiner the death certificate be executed physician and resulting in death) Last Due to (or as a consequence of): Box 68760, the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Inknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No probable 1 Tes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perforn this certificate Vital عرط 0 XIO il or Attending Physician: after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 9 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0053568 26,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Checoptake A 1 hoteson 6 32. Begistrar's Signatur Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** <sup>Day</sup> 2008 Feb. 26, 3:45 S. Рм Steele Agnes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City M/A Keswick Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 2, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F 84 Scotland Director 264-26-8293 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural;" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must he marified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1X Yes 2 □ No Directo Md. N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Warrenton Road 21210 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be S. David Smi th Margaret G. Sharp 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith S. Fusting/Daughter 102 Warrenton Rd. Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Deer Creek Harmony Cem. 3/1/08 Darlington, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipense 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. me Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ATHEROScherotic Cordioversola Disciss resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1☐ Yes the Hospital or Attending Physician: pin 24 hours after death. the Funeral Director; After this certified 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2/26/08 D0054056 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Salvie

2008

31. Date filed (Month, Day, Year) FEB 2 8 Rd

Registrar's Signature

Bat MO

| 08-01590         |  |
|------------------|--|
| Donna Kaye Smith |  |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | No.                               |                                                     |  |  |  |
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| Physici                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                            | Decedent's Name (First, Middle,Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   |                                             |                        | 2. Date of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                   | 3. Time of Death                                    |  |  |  |
| dical Exami                                                                                                                                                                                                                                                                                                                                                                                          | iner                                                                                                                                                                                                                                                                                                                                       | Donna Kaye Smith                                                                                                                                                                                                                                                                   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              |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                            | 4a. Facility Name (if not institution, give stre<br>7900 Benesch Circle Apartme                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | Glen Burni                                  | r Location of Death    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | . County of Death<br>Anne Arundel |                                                     |  |  |  |
| Forest                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                            | 5. Social Security Number 6. Sex                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 7. Age (In yrs. last bi           |                                             |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | thplace (State or Foreign                           |  |  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                            | 216-78-1816 1 M                                                                                                                                                                                                                                                                    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              |  |  |  |
| any                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                            | Usual Residence of Decedent  10a. State 10b. County                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 10c. City, Tow                    | n or Location                               |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | 10d. Inside City Limits                             |  |  |  |
| <b>3</b>                                                                                                                                                                                                                                                                                                                                                                                             | _                                                                                                                                                                                                                                                                                                                                          | MD Anne Arund                                                                                                                                                                                                                                                                      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| Aaryland<br>28a-f show<br>I at once.                                                                                                                                                                                                                                                                                                                                                                 | cto                                                                                                                                                                                                                                                                                                                                        | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | er Gren i                         | 10f. Zip Code                               |                        | 10g. Cit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | izen of What Cou                  | ntry?                                               |  |  |  |
| he Ma<br>or 28<br>fied 3                                                                                                                                                                                                                                                                                                                                                                             | Director                                                                                                                                                                                                                                                                                                                                   | 7000 Paragab Circle                                                                                                                                                                                                                                                                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| vith t                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                            | 7900 Benesch Circle 11. Mantal Status 12.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Was Decedent Ever in U.S.         | 13. Was Decedent of H                       | lispanic Origin? ( Spe |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | ican Indian, Black,                                 |  |  |  |
| eath<br>item<br>ust b                                                                                                                                                                                                                                                                                                                                                                                | Funeral                                                                                                                                                                                                                                                                                                                                    | 1 Never Married 2 Married                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Armed Forces? Yes 2 X No          | If Yes, specify Cuba                        | an, Mexican, Puerto F  | Rican, etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | White, etc.                       |                                                     |  |  |  |
| fter d<br>I", or                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                            | 3 Widowed 4 X Divorced If Ye                                                                                                                                                                                                                                                       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| ours a<br>atura<br>camir                                                                                                                                                                                                                                                                                                                                                                             | d by                                                                                                                                                                                                                                                                                                                                       | 15. Decedent's Education (Specify only high                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ghest grade completed) 16a        | a. Decedent's Usual Occup                   | ation (Give kind of we |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Kind of Business/                 | Industry                                            |  |  |  |
| 72 hk                                                                                                                                                                                                                                                                                                                                                                                                | leted                                                                                                                                                                                                                                                                                                                                      | Elementary/Secondary (0-12)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | College (1-4 or 5+)               | during most of working lif                  | e. DO NOT use retire   | ea)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                   |                                                     |  |  |  |
| L 13-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica                                                                                                                                                                                                                                                                                                                            | Comple                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                    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              |  |  |  |
| Hygi<br>Hoth                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                            | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                   |                                             |                        | First, Middle, Maider                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Surname)                          |                                                     |  |  |  |
| 16<br>d be f<br>lental<br>arke                                                                                                                                                                                                                                                                                                                                                                       | Be                                                                                                                                                                                                                                                                                                                                         | James A. Sisk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2                                 | 2) 11-17-11-11-11-11-11-11-11-11-11-11-11-1 | Betty Jo               | and the latest and the same of |                                   | 7: 0:1)                                             |  |  |  |
| b 21<br>should<br>and Me<br>7 is man                                                                                                                                                                                                                                                                                                                                                                 | T <sub>0</sub>                                                                                                                                                                                                                                                                                                                             | 19a. Informant's Name/Relationship (Type, Ms. Debbie Miller/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4                                 | 9b. Mailing Address (Stre                   |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | -                                 |                                                     |  |  |  |
| , ML 2 sho<br>ealth and<br>em 27 is<br>raumati                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                            | 20a. Method of Disposition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   | e of Disposition (Name of c                 |                        | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Location - City or                |                                                     |  |  |  |
| of He                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                            | 1 Burial 2 X Cremation 3 R                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | emoval from State crem            | atory or other place)                       | -                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | •                                 |                                                     |  |  |  |
| Pag<br>ment<br>tant:                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                            | 4 Donation 5 Other Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                   | apeake Cremat                               | cion   02/             | 28/2008 St                                                                                                               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              |  |  |  |
| BAITIMORE, MID 21215-UU36 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens Department of Health and Mental Hygiens in "matural", or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once |                                                                                                                                                                                                                                                                                                                                            | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Moi357 1 2nd Ave. SW, Glen Burnie, MD 210                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                   |                                             |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                     |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                   |                                             |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                     |  |  |  |
| Physician<br>Medical/                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                            | failure: List only one cause on each line.                                                                                                                                                                                                                                         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| xaminer                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                            | Immediate Cause (Final disease or condition resulting in death)  a. Complications of Head Injuries  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   |                                             |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                     |  |  |  |
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|                                                                                                                                                                                                                                                                                                                                                                                                      | ē                                                                                                                                                                                                                                                                                                                                          | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):                                                                                                                                                                                        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| cuted<br>ind<br>transit                                                                                                                                                                                                                                                                                                                                                                              | Examiner                                                                                                                                                                                                                                                                                                                                   | events resulting in death) Last                                                                                                                                                                                                                                                    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| 760, icate be ex physician the burial                                                                                                                                                                                                                                                                                                                                                                | Medical                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23a, 27, 28                       | Ba-f per me                                 | g877 3-21              | <u>-08 vt</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 3d. Date of deliver               |                                                     |  |  |  |
| tifica<br>mg pł                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                            | 23b. Was decedent pregnant in the past 12 months?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Live birth                        | 2 Fetal death 3                             | Ectopic pregnar        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | Day Year                                            |  |  |  |
| DOX OO<br>e death certif<br>the attending<br>ed for use as                                                                                                                                                                                                                                                                                                                                           | ician/                                                                                                                                                                                                                                                                                                                                     | 4                                                                                                                                                                                                                                                                                  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| e dea<br>the a                                                                                                                                                                                                                                                                                                                                                                                       | Physic                                                                                                                                                                                                                                                                                                                                     | 1 Yes 2 No 9 V Unknown g                                                                                                                                                                                                                                                           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| v requires that the det<br>been signed by the should be detached for                                                                                                                                                                                                                                                                                                                                 | by P                                                                                                                                                                                                                                                                                                                                       | Part II. Other significant conditions conf                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | tributing to death but not result | ting in the underlying cause                | e given in Part I.     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | the cause of death?                                 |  |  |  |
| J, F<br>Lires t<br>1 sign<br>d be c                                                                                                                                                                                                                                                                                                                                                                  | ag la                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                    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| v request should                                                                                                                                                                                                                                                                                                                                                                                     | Completed                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                             |                        | 24a. Was an autopsy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                   | utopsy findings available<br>completion of cause of |  |  |  |
| he lar<br>ate ha                                                                                                                                                                                                                                                                                                                                                                                     | E O                                                                                                                                                                                                                                                                                                                                        | performed? dea<br>1 ✓ Yes 2 No 1 ✓                                                                                                                                                                                                                                                 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| cian: The law<br>certificate has                                                                                                                                                                                                                                                                                                                                                                     | O)                                                                                                                                                                                                                                                                                                                                         | b 25. Was case referred to medical 26.Place of Death (Check only one)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                   |                                             |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                     |  |  |  |
| VILAI NEC<br>ysician: The<br>his certificate<br>director, page                                                                                                                                                                                                                                                                                                                                       | 0 8                                                                                                                                                                                                                                                                                                                                        | examiner?    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other   Nursing Home 5   Residence 6   Other   Nursing Home 5   Residence 6   Other   Nursing Home 5   Residence 6   Other   Nursing Home 5   Nur |                                   |                                             |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                     |  |  |  |
| II OI VITAI KECOLUS, ding Physician: The law require 1. After this certificate has been si funeral director, page 2 should b                                                                                                                                                                                                                                                                         | -                                                                                                                                                                                                                                                                                                                                          | 27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                   |                                             |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                     |  |  |  |
| tendin<br>eath.<br>for: A                                                                                                                                                                                                                                                                                                                                                                            | 흲                                                                                                                                                                                                                                                                                                                                          | Pending Investigation 1996 unknown 1 Yes 2 No subject involved                                                                                                                                                                                                                     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| DIVISION  tal or Attendiu  rs after death.  al Director: A  led in by the fu                                                                                                                                                                                                                                                                                                                         | lice<br>Hice                                                                                                                                                                                                                                                                                                                               | 3 Suicide 6 Could not be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 28e. Place of Injury - At home,   |                                             | building, etc.         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | and Number or R                   | ural Route Nacción                                  |  |  |  |
| pital or<br>ours afte<br>eral Dir<br>filled in                                                                                                                                                                                                                                                                                                                                                       | ert                                                                                                                                                                                                                                                                                                                                        | 4 Homicide determined                                                                                                                                                                                                                                                              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              |  |  |  |
| Invision of yield needs that he don't he law requires that the death certificate hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it                                                                                                                          | alC                                                                                                                                                                                                                                                                                                                                        | 29a. Certifier 1 Certifying Physician:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | To the best of my knowledge, o    | death occurred at the time,                 | date and place, and    | due to the cause(s) a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ind manner as sta                 | ted.                                                |  |  |  |
| o the<br>ithin<br>o the<br>omple                                                                                                                                                                                                                                                                                                                                                                     | Homicide determined (Specify) UNKNOWN  29a. Certifier (Check only one)  2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (M. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                             |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                     |  |  |  |
| F 3 F 8                                                                                                                                                                                                                                                                                                                                                                                              | Ne.                                                                                                                                                                                                                                                                                                                                        | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                   | 29c. Lice                                   | nse number             | 29d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | . Date signed (Me                 | onth, Day, Year)                                    |  |  |  |
| •                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                            | Quest 2                                                                                                                                                                                                                                                                            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|                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                            | 30. Name and address of person who comp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | leted cause of death (Item 23a    | a)                                          |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                     |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                            | Ana Rubio MD. Assistant M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ledical Examiner 111              | 1 Penn Street, Baltin                       | nore, MD 21201         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                     |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                            | 31. Date filed (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 32. Registrar's Signature         | <i>B</i>                                    |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                     |  |  |  |
| Regis                                                                                                                                                                                                                                                                                                                                                                                                | trar                                                                                                                                                                                                                                                                                                                                       | FEB 2 8 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Att Care of the                   | Asset J                                     |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                     |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar America #1, perMD, g876, 2/28/C8 TT Certificate of Death Reg. No.- Decedent's Name (First, Middle, Last)
 Genya Shteyman. 2. Date of Death 3. Time of Death **Physician** SHTEYMAN FEBRUARY 22 2008 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3615 FORDS LANE, #504 BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 VF 218-57-0753 80 Director 05/12/1927 UKRAINE Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or nother traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at MD 1 XYes 2 No N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3615 FORDS LANE, #504 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏ Yes 2 (XX) No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo þ Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER HOTEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AVRAM **FUTERMAN** 2 SHEINDEL DORFMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEONID SHTEYMAN / SON 7 WINDBLOWN COURT, #301, BALTIMORE,MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 02/24/2008 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE **Physician** 1 Month /Medical Due to (or as a consequence of): **Examiner** PATENSINE Si quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed physician and s the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as IF FEMALE: for use If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Division or Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 1 Tes ဥ 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Seath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 Pending investigation Natural

Accident Injury To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signatur and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name : and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

JAKO BON

Year)

8

ND

32. Registrar's Signature

2835

SMITH AVE BALT

|                                                                                                                                | 1                                                           | For State                                                                                                                                                  | State of M                                                        | larylan                       |                                                      | artment<br><i>rtificate</i>         |                           |                                               | ind Me                                                  | ntal Hy                            | ()                               | 000                                             | 06210                                              |
|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------|------------------------------------------------------|-------------------------------------|---------------------------|-----------------------------------------------|---------------------------------------------------------|------------------------------------|----------------------------------|-------------------------------------------------|----------------------------------------------------|
| Physicia                                                                                                                       |                                                             | 1. Decedent's Name (First, Middle, L<br>ELIZABETH M. STO                                                                                                   |                                                                   |                               |                                                      | imoato                              | 07 1                      | Joann                                         | 2                                                       | . Date of De                       | Reg. No.<br>eath<br>Day          | . 0 0 0                                         | 3. Time of Death                                   |
| /Medica<br>Examine                                                                                                             | al -                                                        | 4a. Facility Name (If not institution, gas<br>CALVERT HEALTH (                                                                                             | ve street and number                                              | )                             |                                                      |                                     |                           | Location of                                   | f Death                                                 | FEB.                               | 25<br>4c.                        | 2008 County of Death CECIL                      | 7:20 a <sup>™</sup>                                |
| Funeral<br>Director                                                                                                            |                                                             | 161-14-6175                                                                                                                                                | Sex 7. A<br>1 □ M 2 🕅 F                                           | ge (In yrs. i                 | las <i>t birthd</i> ay)<br>Yrs.                      | If Under 1<br>Months                | Year<br>Days              | If Under 2<br>Hours                           | Min.                                                    | Date of Bi<br>(Month, Da<br>0/16/1 | ay, Year)                        |                                                 | place (State or Foreign<br>ntry)  PA               |
| e Maryland<br>Sa-f show<br>tiffled at                                                                                          | Director                                                    | Usual Residence of Decedent  10a. State 10b. County  PA CHESTI                                                                                             | ER .                                                              |                               | y, Town or Lo                                        |                                     |                           |                                               |                                                         |                                    |                                  |                                                 | 10d. Inside City Limits 1 □Yes 2 No                |
| th with th                                                                                                                     | al Dire                                                     | 10e. Street and Number 2793 NEWARK RD                                                                                                                      |                                                                   |                               |                                                      | 10f. Zip 0                          | ode<br>.939               | 0                                             |                                                         | 10g. Citizen of Wha                |                                  |                                                 | ntry?                                              |
| urs a                                                                                                                          | by Fur                                                      | 11. Marital Status<br>1  ☐ Never Married 2                                                                                                                 | 12. Was Deceden Armed Forces 1 Tyes 2 If Yes, Give Year or Dates: | ?<br><b>K</b> No              |                                                      | Was Decede                          | nt of Hi<br>fy Cuba       |                                               | gin? (Speci<br>, Puerto Ri                              | fy Yes or No<br>can, etc.)         |                                  | 14. Race - Ameri<br>Black, White,               |                                                    |
| within 72 ho<br>ene.<br>than "natur<br>he Medical I                                                                            | Completed                                                   | 15. Decedent's (Specify only highest g                                                                                                                     | Education<br>rade completed)<br>College (1-4or                    | (Give<br>life.                | dent's Usual<br>kind of work<br>DO NOT use<br>MEMAKE | done d<br>retired                   | ation<br>during most<br>) | of working                                    |                                                         |                                    | ind of Business/Industry  N HOME |                                                 |                                                    |
| 2 should be filed withing and Mental Hyglene. Is marked other than aumatic event, the M                                        | a a                                                         | 17. Father's Name (First, Middle, Last FRANKLIN REED                                                                                                       | •                                                                 |                               | I                                                    |                                     |                           |                                               |                                                         | First, Middle                      |                                  |                                                 |                                                    |
| and 2 should be ealth and Mental n 27 is marked coer traumatic even                                                            | 2                                                           | 19a. Informant's Name/Relationship ROBERT STOVER-SO                                                                                                        | (Type. Print)                                                     |                               |                                                      | ng Address (                        |                           | and Numbe                                     | r or Rural                                              |                                    |                                  | or, City or Town, State, Zip Code) VE, PA 19390 |                                                    |
| Pages 1 au<br>nent of Hea<br>nrt: If Item<br>iry or othe                                                                       |                                                             | 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec                                                                        |                                                                   |                               | Place of Disponentery, cree                          | esition (Name<br>matory or oth      | e of<br>ner plac          |                                               | Da                                                      | te                                 | 20c. Lo                          | ocation - City or T                             | own, State                                         |
| permit. Departn Importa any inju                                                                                               |                                                             |                                                                                                                                                            |                                                                   |                               |                                                      |                                     |                           |                                               |                                                         |                                    |                                  |                                                 | HOME, INC                                          |
| Physician<br>/Medical                                                                                                          |                                                             | 23a Part1 Enter the disease, or co<br>book or heart him. Lift on<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)                  | mplications that cause<br>y one cause on each<br>a                | erna                          | tremi                                                | er the mode                         | of dyin                   | g, such as                                    | cardiac or                                              | respiratory a                      | arrest,                          |                                                 | Approximate Interval Between Onset and Death       |
| icate be executed bhysician and sthe burial-transit                                                                            | edical Examiner                                             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause () lease of injury that initiated events resulting in death) Last | b                                                                 | ·                             | ·                                                    |                                     |                           |                                               |                                                         |                                    |                                  |                                                 |                                                    |
| the death certificate be executed the attending physician and ched for use as the burial-transit                               | Physician/Medica                                            | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown                                                                         | d                                                                 | 2 🗆 Feta                      | Ideath 3                                             | ⊒Ectopic pre<br>⊒ Other <i>(spe</i> |                           | ,                                             |                                                         |                                    |                                  | 23d. Date of deliv                              | rery<br>Day Year                                   |
| w requires that the de been signed by the a should be detached to                                                              | 2                                                           | Part II. Other significant conditions Senile d                                                                                                             |                                                                   | but not resi                  | ulting in the u                                      | nderlying ca                        | use give                  | en in Part I.                                 |                                                         |                                    |                                  |                                                 | the cause of death?                                |
| an: The law requificate has been or, page 2 should                                                                             | e Completed                                                 | 25. Was case referred to medical                                                                                                                           |                                                                   |                               |                                                      |                                     |                           | 26 Plana                                      | of Dooth                                                | 1□ Yes                             | opsy<br>ormed?<br>2 <b>30</b> 0  | prior to co                                     | opsy findings available ompletion of cause of 2 No |
| Physical this of all dire                                                                                                      | cation: To Be                                               | examiner?  1   Yes   2000   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other:                                                                     |                                                                   |                               |                                                      |                                     |                           | er: 🔼 Nui<br>y at<br>k?                       | <b>4</b> Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |                                    |                                  |                                                 |                                                    |
| To the Hospital or Attending is within 24 hours after death.  To the Funeral Director: After completely filled in by the funer | 27. Manner of Death   Day 1   Day 1   Day 2   Day 2   Day 3 |                                                                                                                                                            |                                                                   |                               |                                                      |                                     |                           |                                               |                                                         |                                    |                                  |                                                 |                                                    |
| To the Hospital or within 24 hours afte To the Funeral Discompletely filled in                                                 | Medical                                                     |                                                                                                                                                            | aminer: On the basis<br>and manners                               | of examina                    |                                                      | vestigation,                        | in my o                   | pinion, dea                                   |                                                         |                                    | , date an                        | d place, and due                                | to the cause(s)                                    |
| F × F 8                                                                                                                        |                                                             | 30. Name and address of person wh                                                                                                                          | 1 23a) (Type                                                      | 29c. License number  DOS 5835 |                                                      |                                     |                           | 29d. Date signed (Month, Day, Year)  O2 26 08 |                                                         |                                    | 9,/                              |                                                 |                                                    |

State Registrar NEIL E. LATTIN, MD 101 COLONIAL

FEB 2 8 2008

32 Registrar's Signature

31. Date filed (Month, Day, Year)

Way, Rising Sun, MO 21911

|                    |                                                                                                                                                                                                                                                                                       | 1                                                                                                                   | For State                                                                                                                                                                   |                      | State                    | of Mary                     | land / De                        | partmer<br><i>ertifica</i> |                            |                                |            | Mental H           | ygien<br>Reg. N   | - / 1111.0                      | 06211                                             |  |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------|-----------------------------|----------------------------------|----------------------------|----------------------------|--------------------------------|------------|--------------------|-------------------|---------------------------------|---------------------------------------------------|--|
|                    | Physicia                                                                                                                                                                                                                                                                              |                                                                                                                     | 1. Decedent's Name (First, Middle, Last)                                                                                                                                    |                      |                          |                             |                                  | ce i                       | 2. Date of Do<br>Month     |                                |            |                    |                   | Death Day Year 3. Time of Death |                                                   |  |
|                    | /Medic                                                                                                                                                                                                                                                                                | al -                                                                                                                | Paul  a. Facility Name (If r                                                                                                                                                |                      |                          |                             | City, Town, or Location of Death |                            |                            | 02                             | 2 3        | th                 |                   |                                 |                                                   |  |
|                    | Examin                                                                                                                                                                                                                                                                                | er '                                                                                                                | Upper Che                                                                                                                                                                   |                      |                          |                             | ter                              |                            | l Air                      |                                |            |                    |                   | Harford                         |                                                   |  |
| - 3-7-             | Funeral                                                                                                                                                                                                                                                                               | į                                                                                                                   | Social Security Nu                                                                                                                                                          |                      | 6. Sex                   | 7. Age (li                  | n yrs. last birtho               | lay) If Unde               | er 1 Year                  | If Unde                        | er 24 Hrs. | 8. Date of (Month) | Birth             |                                 | thplace (State or Foreign                         |  |
|                    | Director                                                                                                                                                                                                                                                                              |                                                                                                                     | 218-14-63                                                                                                                                                                   | 322                  | 1 <b>∑</b> M 2□F         | 8                           | 3 Yr                             | Months.                    | Days                       | Hours                          | Min.       | 09-08              | 192               | 4 Mai                           | yland                                             |  |
|                    |                                                                                                                                                                                                                                                                                       |                                                                                                                     | Usual Residence of D                                                                                                                                                        | Decedent             |                          | 140                         | c. City, Town o                  | Location                   |                            |                                |            |                    |                   |                                 | 10d. Inside City Limits                           |  |
|                    | rylan<br>show                                                                                                                                                                                                                                                                         |                                                                                                                     | 10a. State                                                                                                                                                                  | 10b. County          |                          | "                           | ,,                               |                            |                            |                                |            |                    |                   |                                 | 1 ☐ Yes 2√ No                                     |  |
|                    | e Ma<br>3a-f s                                                                                                                                                                                                                                                                        | 5                                                                                                                   | Maryland                                                                                                                                                                    | Harfo                | rd                       |                             | Bel A                            |                            |                            |                                |            |                    | 10- 0             | Citizen of What Co              | 11                                                |  |
| =                  | or 28                                                                                                                                                                                                                                                                                 | Funeral Director                                                                                                    | 10e. Street and Num                                                                                                                                                         |                      |                          |                             |                                  |                            | ip Code                    |                                |            |                    |                   |                                 | Surid y :                                         |  |
|                    | filed within 72 hours after death with the Maryland<br>Hygiene.<br>uther than "natural", or items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at                                                                                                                  |                                                                                                                     | 401 G Agg                                                                                                                                                                   | gies Ci              |                          | ecedent Eve                 | rinlle                           |                            | 21014                      |                                | Origin? (S | pecify Yes or      |                   | J.S.A.<br>14. Race - Ame        | erican Indian,                                    |  |
| _                  | er de<br>Items                                                                                                                                                                                                                                                                        |                                                                                                                     | 11. Marital Status                                                                                                                                                          | al OT Manni          | Armed                    | Forces?                     | rino.s.                          | If Yes, sp                 | ecify Cuba                 | in, Mexic                      | an, Puer   | to Rican, etc.)    | 110               | Black, Whi                      |                                                   |  |
| 36                 | s afte                                                                                                                                                                                                                                                                                | by F                                                                                                                | 1 ☐ Never Married 2 ሺ Married 1 ሺ Yes 2 ☐ No<br>If Yes, Give 1 ☐ Y<br>3 ☐ Widowed 4 ☐ Divorced Year or Dates:                                                               |                      |                          |                             |                                  | 1 ☐ Yes                    | Yes 2█ No <i>Specify</i> : |                                |            |                    |                   | Specify: W                      | hite                                              |  |
| $\frac{000}{2}$    | hour<br>tural                                                                                                                                                                                                                                                                         | ed                                                                                                                  | 15. Decedent's Education 16a. Decedent's Usual Occupation                                                                                                                   |                      |                          |                             |                                  |                            | 1.2                        | 16b. Kind of Business/Industry |            |                    |                   |                                 |                                                   |  |
| )<br>215           | in 72<br>n "ne<br>Aedic                                                                                                                                                                                                                                                               | plet                                                                                                                | (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)                                                             |                      |                          |                             |                                  |                            |                            |                                |            |                    |                   |                                 |                                                   |  |
| 212                | y with<br>yiene<br>r tha<br>the h                                                                                                                                                                                                                                                     | Completed                                                                                                           | 12                                                                                                                                                                          | idaly (0-12)         | Jonego                   |                             | Sal                              | es                         |                            |                                |            |                    |                   | t. Brewe                        | ry                                                |  |
| Z C                |                                                                                                                                                                                                                                                                                       | Be C                                                                                                                | 17. Father's Name (F                                                                                                                                                        | First, Middle, L     | .ast)                    |                             |                                  |                            |                            |                                |            | ne (First, Mid     | dle, Maid         | en Surname)                     |                                                   |  |
| ं हे               | uld be<br>Menta<br>Irked                                                                                                                                                                                                                                                              | 10E                                                                                                                 | Paul Tosl                                                                                                                                                                   | kes                  |                          |                             |                                  |                            |                            |                                |            | lotta              |                   |                                 |                                                   |  |
| Maryland           | 2 should be filed wand Mental Hygie is marked other tiraumatic event, the                                                                                                                                                                                                             |                                                                                                                     | 19a. Informant's Na                                                                                                                                                         | _                    |                          |                             |                                  | _                          |                            |                                |            |                    |                   | y or Town, State,               | Zip Code)                                         |  |
| 1.7                | and and a salth                                                                                                                                                                                                                                                                       |                                                                                                                     | Paul Tosl                                                                                                                                                                   | •                    | Son)                     |                             |                                  |                            |                            | Ct B                           | sel A      | ir, MD             |                   | Location - City o               | Town State                                        |  |
| 그 8                | of He                                                                                                                                                                                                                                                                                 |                                                                                                                     | 20a. Method of Dispo                                                                                                                                                        |                      | 3 □Removal fro           | m State                     | 20b. Place of D<br>cemetery,     | crematory o                | ame or<br>r other plac     | ce)                            |            |                    |                   |                                 |                                                   |  |
| J.E                | Pag<br>ment<br>ant: I                                                                                                                                                                                                                                                                 |                                                                                                                     | 4 ☐ Donation                                                                                                                                                                | 5 🗆 Other (Sp        | pecify)                  |                             | Arling                           |                            |                            |                                |            | 04-200             |                   |                                 | , Virginia                                        |  |
| メスクロ<br>Baltimore, | permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.                                                                                                                                                  |                                                                                                                     | 21. Signature of Fur                                                                                                                                                        | neral Service        | icensee                  | 00                          |                                  | 22. Name                   |                            |                                | D.C        |                    |                   | enral Ho<br>Air, MD             | me of Be <b>l</b> Air<br>21014                    |  |
| ് ∎                |                                                                                                                                                                                                                                                                                       |                                                                                                                     | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between |                      |                          |                             |                                  |                            |                            |                                |            |                    |                   |                                 |                                                   |  |
|                    | Physician                                                                                                                                                                                                                                                                             |                                                                                                                     | Immediate Cause (Final disease or condition resulting in death)  A cute rugs condid (infanction)  a. A cute rugs condid (infanction)                                        |                      |                          |                             |                                  |                            |                            |                                |            |                    |                   |                                 |                                                   |  |
|                    | /Medical                                                                                                                                                                                                                                                                              |                                                                                                                     | resulting in death)  Due to (or as a consequence of):                                                                                                                       |                      |                          |                             |                                  |                            |                            |                                |            |                    |                   |                                 |                                                   |  |
|                    | Examiner                                                                                                                                                                                                                                                                              |                                                                                                                     | Sequentially list conditions.                                                                                                                                               |                      |                          |                             |                                  |                            |                            |                                |            |                    |                   |                                 |                                                   |  |
|                    | p #                                                                                                                                                                                                                                                                                   | Examiner                                                                                                            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.                                        |                      |                          |                             |                                  |                            |                            |                                |            |                    |                   |                                 |                                                   |  |
|                    | ecute<br>and<br>-trans                                                                                                                                                                                                                                                                |                                                                                                                     | that initiated events resulting in death) Last  Due to (or as a consequence of):                                                                                            |                      |                          |                             |                                  |                            |                            |                                |            |                    |                   |                                 |                                                   |  |
| 8760,              | cate be executed physician and the burial-transit                                                                                                                                                                                                                                     |                                                                                                                     | , -                                                                                                                                                                         |                      | l Due                    | 10 (01 43 4 1               | oniocquonioc oi                  | ,.                         |                            |                                |            |                    |                   |                                 |                                                   |  |
| 98                 | cate<br>physi<br>the l                                                                                                                                                                                                                                                                | dical                                                                                                               |                                                                                                                                                                             |                      | d                        |                             |                                  |                            |                            |                                |            |                    |                   |                                 |                                                   |  |
| 于<br>0xe           | certifi<br>Iding<br>Ise at                                                                                                                                                                                                                                                            | /Me                                                                                                                 | IF FEMALE:                                                                                                                                                                  | t prognant           | 23c. If yes,             | outcome pf                  | pregnancy                        |                            |                            |                                |            |                    |                   | 23d. Date of d                  | elivery                                           |  |
| <b>=</b> 8         | requires that the death certific<br>een signed by the attending p<br>nould be detached for use as                                                                                                                                                                                     | Physician/Me                                                                                                        | in the past 12                                                                                                                                                              | months?              | 4□Pr                     | egnant at tir               | Fetal death<br>ne of death       | 3 ☐ Ectopic 5 ☐ Other      |                            | У                              |            |                    | Month Day Yea     |                                 |                                                   |  |
| 90                 | the d<br>y the<br>iched                                                                                                                                                                                                                                                               | iysi                                                                                                                | 9☐ Unknown                                                                                                                                                                  |                      | 9□∪                      | nknown                      |                                  |                            |                            |                                |            |                    |                   |                                 |                                                   |  |
| 4 9                | that<br>ned b                                                                                                                                                                                                                                                                         |                                                                                                                     | Part II. Other signif                                                                                                                                                       | ficant condition     | ons contributing t       |                             |                                  |                            |                            | ven in Pa                      | rt I.      |                    |                   |                                 | to the cause of death?                            |  |
| ్లు ట్             | quire;<br>n sig<br>uld be                                                                                                                                                                                                                                                             | g p                                                                                                                 | din                                                                                                                                                                         | sino                 | atrio                    | L f                         | Jon'l                            | lohe                       | n                          |                                |            | 1                  | I ☐ Yes           | 2 <b>□ M</b> 6 3 □              | Probably 4 Unknown                                |  |
|                    | aw re<br>s bee<br>2 sho                                                                                                                                                                                                                                                               | Completed by                                                                                                        | PLE                                                                                                                                                                         | euro                 | 1 el                     | fus                         | 000                              |                            |                            |                                |            |                    | Vas an<br>autopsy | 24b. Were                       | autopsy findings available completion of cause of |  |
| 3 %                | The law<br>te has b                                                                                                                                                                                                                                                                   | luo l                                                                                                               |                                                                                                                                                                             |                      | 1                        |                             |                                  |                            |                            |                                |            | 1 Y                | performed         | l? death                        | ?                                                 |  |
| ∠ital              | lan:<br>rtifica<br>ttor, p                                                                                                                                                                                                                                                            | Be C                                                                                                                | p 25. Was case referred to medical 26. Place of Death (Check only one)                                                                                                      |                      |                          |                             |                                  |                            |                            |                                |            |                    |                   |                                 |                                                   |  |
| 5 b                | ysic<br>direc                                                                                                                                                                                                                                                                         | O 1 ☐ Yes 2 ☐ HO 1 ☐ Horpatient 2 ☐ ER/Outpatient 3 ☐ DOA 3 does 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |                                                                                                                                                                             |                      |                          |                             |                                  |                            |                            |                                | pecify)    |                    |                   |                                 |                                                   |  |
| 200                | ttending Physician:<br>Jeath.<br>Stor: Affer this certifica<br>the funeral director, I                                                                                                                                                                                                | :uo                                                                                                                 | 27. Manner of Death                                                                                                                                                         | 5 Pendir             | q (/                     | ate of Injury<br>Month, Day |                                  | jury                       | 28c. Inju<br>Wo            |                                |            | 28d. Desci         | ribe how i        | njury occurred                  |                                                   |  |
|                    | tendi<br>eath.<br>or: A<br>the fu                                                                                                                                                                                                                                                     | catio                                                                                                               | 2 Accident                                                                                                                                                                  | investi<br>6 ☐ Could | gation                   |                             | A41                              | M atract for               |                            | ]Yes 2                         |            | 20f Locati         | on (Stree         | t and Number or                 | Rural Route Number,                               |  |
| 105                | or At<br>after d<br>Direct<br>in by                                                                                                                                                                                                                                                   | Certification:                                                                                                      | 4 ☐ Homicide                                                                                                                                                                | determ               | :   400. F               | uilding, etc.               | y - At home, far<br>(Specify)    | II, Street, Iac            | tory, office               |                                |            | City o             | r Town, S         | tate)                           | Tarar Fronto Transor,                             |  |
| N O                | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as: | al Ce                                                                                                               | 29a. Certifier<br>(Check only                                                                                                                                               | 1 Certifyin          | ng Physician: To         | the best of                 | my knowledge                     | death occur                | red at the t               | time, date                     | e and pla  | ce, and due to     | the caus          | e(s) and manner                 | as stated.                                        |  |
| \S                 | the Ho<br>in 24<br>the Fu                                                                                                                                                                                                                                                             | Medical                                                                                                             | one) and manner stated.                                                                                                                                                     |                      |                          |                             |                                  |                            |                            |                                |            |                    |                   |                                 |                                                   |  |
| 7                  | To the within 2. To the I complet                                                                                                                                                                                                                                                     | Σ                                                                                                                   | 29b. Signature and                                                                                                                                                          | title of certifie    | 1                        |                             | 1                                | )                          |                            |                                | _          | 4                  |                   |                                 | ,                                                 |  |
|                    |                                                                                                                                                                                                                                                                                       |                                                                                                                     | 1/                                                                                                                                                                          | 1/1                  | Mouree MD 247824         |                             |                                  |                            |                            | (                              | 12/2-      | 1/2008             |                   |                                 |                                                   |  |
|                    | 10                                                                                                                                                                                                                                                                                    |                                                                                                                     | 30. Name and addi                                                                                                                                                           |                      | who completed            | cause of dea                | ath (Item 23a) (                 | Type, Print)               | 2/22                       | ^                              | 11         | 00-                | 1.0               | M                               | D 21001                                           |  |
|                    | Ce                                                                                                                                                                                                                                                                                    |                                                                                                                     | 31. Date filed (Mon                                                                                                                                                         | oth. Day. Year       | - C /                    | 6 /                         | 's Signature                     | en 0                       | coru                       | 2 ,                            | 40         | ene                | ree               | ~ / ′                           | D C 1001                                          |  |
|                    | St<br>Regist                                                                                                                                                                                                                                                                          | ate<br>trar                                                                                                         | JI. Date med (Mon                                                                                                                                                           | EED                  | 2 8 2008                 | Dan.                        | Cerde<br>'s Signature            | · An                       | A September 1              |                                |            |                    |                   |                                 |                                                   |  |
|                    |                                                                                                                                                                                                                                                                                       |                                                                                                                     |                                                                                                                                                                             | 1 1 1                | The second of the second | (Car ) 1                    | 2000                             | # 1                        |                            |                                |            |                    |                   |                                 |                                                   |  |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear Month **Physician** June A. Teves February 22, 2008 9:05 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Towson
If Under 1 Year Baltimore last birthday) 8. Date of Birth (Month, Day, Year) 02-07-1941 If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1□ M 2X F Hours 67 220-40-9252 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes ŽÜNo Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1997 Pimlico Court 21050 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Completed by 3 ☐ Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Social Security Admin. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward R. Glover Kathleen Farrell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1997 Pimlico Ct Forest HI11 MD 21050 Jonathan W. Fuller (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Moreland Mem. Park 02-25-2008 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COP stage VZI /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physician Physician/Medical the IF FEMALE nse. 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an page 2 autopsy performed? res 2 💢 No 1 Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 □ DOA 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred A fter Hospital or Attending 1 XNatural 5 Pending within 24 hours are cor.

To the Funeral Director: # 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D52197 2-22-2008 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) 6701 N. CHARLES ST. BALTIMORE MP 21204 10 REKHA MOTAGI aBMC 31. Date filed (Month, Day, Year) FEB 2 32. Registrar's Signature

State Registrar

8 2008

Maryland 2121

Baltimore,

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

| xaminer                                                                              | Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. ANCEA  Due to (or as a consequence of):                                                                                                                    |                                          |                                                                                                                                                       |                      |                                   |                                                                                 |         |  |  |
|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------|---------------------------------------------------------------------------------|---------|--|--|
| Completed by Physician/Medical Examiner                                              | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 100 9 □ Unknown                                                                                                                                                                                                                                                                                                        | d                                        |                                                                                                                                                       |                      |                                   |                                                                                 |         |  |  |
| Completed by P                                                                       | Part II. Other significant conditions of                                                                                                                                                                                                                                                                                                                                                      | n 24b. Were prior to death?              | e contribute to the cause of death?  No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No |                      |                                   |                                                                                 |         |  |  |
| Be                                                                                   | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No                                                                                                                                                                                                                                                                                                                                       | Hospital: 1 ☐ Inpatient 🏖                | ER/Outpatient 3□                                                                                                                                      | Othori               | ath (Check only on                | ence 6 Other (Sp                                                                | ageifu) |  |  |
| Medical Certification: To                                                            | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation                                                                                                                                                                                                                                                                                                                             | 28a. Date of Injury<br>(Month, Day Year) | 28b. Time of Injury M                                                                                                                                 | 28c. Injury at Work? |                                   | how injury occurred                                                             |         |  |  |
| Sertific                                                                             | 3 Suicide 6 Could not b 4 Homicide determined                                                                                                                                                                                                                                                                                                                                                 |                                          | ome, farm, street, fact                                                                                                                               | ory, office          | 28f. Location (St<br>City or Town | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |         |  |  |
| edical (                                                                             | 29a. Certifier (Check only one)  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                          |                                                                                                                                                       |                      |                                   |                                                                                 |         |  |  |
| Ž                                                                                    | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                         |                                          | 2                                                                                                                                                     | 29c. License number  | 2                                 | 9d. Date signed (Month, Day, Year)                                              |         |  |  |
|                                                                                      | Water F.                                                                                                                                                                                                                                                                                                                                                                                      | Atha NI                                  |                                                                                                                                                       | 10052051             | 1                                 | ES 1                                                                            | 6 2008  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) |                                                                                                                                                                                                                                                                                                                                                                                               |                                          |                                                                                                                                                       |                      |                                   |                                                                                 |         |  |  |
|                                                                                      | Walter Atha M.D.                                                                                                                                                                                                                                                                                                                                                                              |                                          |                                                                                                                                                       | wy, Columbia,        | MD 21044                          | +                                                                               |         |  |  |
| te<br>ar                                                                             | 31. Date filed (Month, Day, Year)  FEB 2 8 2008  32. Registrar's Signature                                                                                                                                                                                                                                                                                                                    |                                          |                                                                                                                                                       |                      |                                   |                                                                                 |         |  |  |
| 001                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                               | F.T                                      |                                                                                                                                                       |                      |                                   |                                                                                 |         |  |  |
|                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                               |                                          | ORIGINA                                                                                                                                               | L                    |                                   |                                                                                 |         |  |  |

Sta Registi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 8 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death February 27,2008 **Physician** Thrasher 12:00 A<sup>M</sup> Kathryn J. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris
5. Social Security Number | 6.5 Baltimore Timonium 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF Director 212-22-0692 81 Oct. 13,1926 Italy Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Timonium 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21093 U.S.A. 205 Chantrey Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>6</u> Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If Item 27 Is marked other than any Injury or other transmission. 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Not Available Salvadore 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Chantrey Road Timonium, Maryland 21093 Richard B. Thrasher, Jr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-1-2008 Hilltop Service Corp. Towson Maryland 21. Signature of Puneral Setvice Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 12) Hagan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ifjury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA

Vital Records, P.O. Box 68760 KATHRYN THRASHER To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified ō Division

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12:00

27

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Certification:

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

32 Registrar's Signature

29b. Signature and title of certified

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 2420 M 2008 FEB Benjamin Franklin Trump, M.D. 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Innai Hospital of Baltimore Baltimore City N/A if Under 1 Year | If Under 24 Hrs. Months Days | Hours | Min 5. Social Security Number 6. Sex 1 → M 2 → F 8. Date of Birth Jumouth, 23, Year) 9.32 Mi Scoutt i 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 75 486-36-6069 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Directo N/A Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 500 Hawthorn Road 21210 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. n Mayes 2 No If Yes, Give Year or DatesVietnam 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lyle Franklin Trump Helen Mariel Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Mrs. Elizabeth S. Trump/Wife 500 Hawthorn Road Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Grd. 3/1/08 Timonium, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the dileave, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** 2days /Medical Due to (or 📥 a consequence of): Examiner ia days lostridium Difficile Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to for as a nensequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Stonosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Palmonary 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No Hypertension 24a Was an autopsy
performed?

12 es 2 \( \sum \) No Acute Renal tailure. 0, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES -000 26,2008 February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore 32 Registrar's Signal

DHMH 17 Rev 1/2001

Registrar

|                                                                                                                                                                                                                                                                                                                                    |                  | 1 - For State Registrar Amend #8 per I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | State of Marylar<br>H 0877 3/4/08 TI                                                                      | nd / Den                         |                                                                   | lealth and N                                            | lental Hyg              | •                                                                               | 06216                                                        |                                                          |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------|---------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------|--|--|
| Physic                                                                                                                                                                                                                                                                                                                             |                  | 1. Decedent's Name (First, Middle, Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                  |                                                                   |                                                         | 2. Date of Dea<br>Month | Day 14 Year                                                                     | 3. Time of Death<br>3.50A · M                                |                                                          |  |  |
| /Medi<br>Examir<br>Funeral                                                                                                                                                                                                                                                                                                         |                  | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Northwest Seasons Hospice  Randallstown  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Months Days Hours Min.  Month, Day Month, D |                                                                                                           |                                  |                                                                   |                                                         |                         |                                                                                 | County place (State or Foreign                               |                                                          |  |  |
| Director                                                                                                                                                                                                                                                                                                                           | Funeral Director | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           |                                  |                                                                   |                                                         |                         |                                                                                 |                                                              |                                                          |  |  |
| ith the Mar<br>or 28a-f st                                                                                                                                                                                                                                                                                                         |                  | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | roll                                                                                                      |                                  | Finksbu                                                           | ırg                                                     |                         | 10g. Citizen of What Cou                                                        | 1 □ Yes 2/□ (No intry?                                       |                                                          |  |  |
| eath w                                                                                                                                                                                                                                                                                                                             |                  | 3155 Clarho Cir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 18 12                                                                                                     | _1                               | 048                                                               | pacify Vas or No.                                       | US.                     |                                                                                 |                                                              |                                                          |  |  |
| urs after d                                                                                                                                                                                                                                                                                                                        |                  | 11. Marital Status  1 □ Never Married 2 □ Married  XXWidowed 4 □ Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 □ Yes 272No<br>If Yes, Give<br>Year or Dates:            |                                  | If Yes, specify Cub<br>1 ☐ Yes ※ No                               | dispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | Rican, etc.)            | Carolle                                                                         |                                                              |                                                          |  |  |
| parillinore, Marylatria 4 (2.13-0030) permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-1 show any injury or other traumatic event, the Medical Examination Lighting at ance. | Completed by     | 15. Decedent's Edi<br>(Specify only highest grad<br>Elementary/Secondary (0-12)<br>12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | cation<br>le completed)<br>College (1-4or 5+)                                                             |                                  |                                                                   | pation<br>during most of work<br>d)                     | sing                    | Baltimore (                                                                     | find of Business/Industry<br>ltimore Gas &<br>ectric Company |                                                          |  |  |
| Viditure Auld be filed Mental Hygi arkad other attic event, I                                                                                                                                                                                                                                                                      | To Be Co         | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden  19. William C. Undowkofflox                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                  |                                                                   |                                                         |                         |                                                                                 |                                                              |                                                          |  |  |
| d 2 sho<br>d 2 sho<br>th and<br>7 is mu<br>traumu                                                                                                                                                                                                                                                                                  |                  | 19a. Informant's Name/Relationship (T)  Jay Underkoffler                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | · · · · · ·                                                                                               |                                  |                                                                   |                                                         |                         | r, City or Town, State, Zi                                                      | 50,506,780                                                   |                                                          |  |  |
| Dallinore, i permit. Pages 1 an Department of Heall important: If item 2 any injury or other once.                                                                                                                                                                                                                                 |                  | 20a. Method of Disposition  1258urial 2 Cremation 3 4 Donation 5 Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | Place of Dispo<br>cemetery, crei | Clarho C<br>psition (Name of<br>matory or other plant<br>Park Cem |                                                         | Date                    | ourg MD 2°<br>20c. Location - City or T<br>Woodlawn, I                          | own, State                                                   |                                                          |  |  |
| permit. F<br>Departme<br>Importar<br>any injur                                                                                                                                                                                                                                                                                     |                  | 21. Signature of Funeral Service Lines                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | 22<br>E                          | 2. Name and Addre                                                 | ess of Facility<br>NSS-Seitz                            | Funera]                 | Home, Inc.                                                                      |                                                              |                                                          |  |  |
| Physician /Medical Examiner                                                                                                                                                                                                                                                                                                        | 1                | 23a. Part1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. Figure 1. The Complete Cause (Final day, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                  |                                                                   |                                                         |                         |                                                                                 |                                                              |                                                          |  |  |
| Attending Physicien: The law requires that the death certitica r death.  r death.  ector: Alter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the                                                                                                               |                  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 23c. If yes, outcome of pregn<br>1 Live birth 2 Fets<br>4 Pregnant at time of 6                           | aldeath 3[                       | Ectopic pregnancy                                                 | ,                                                       |                         | 23d. Date of delive Month                                                       | rery<br>Day Year                                             |                                                          |  |  |
| quires that                                                                                                                                                                                                                                                                                                                        | ed by PI         | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the Ca |                                                                                                           |                                  |                                                                   |                                                         |                         |                                                                                 |                                                              |                                                          |  |  |
| lor Attending Physicien: The law requires that the death certaiter doctor. The law requires that the death certain defeath certain the death certain the death certain birector. Page 2 should be detached for use in by the funeral director, page 2 should be detached for use                                                   | To Be            | 24a. Was an autopsy performed? 1 □ Yes 💯 N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                  |                                                                   |                                                         |                         |                                                                                 |                                                              | opsy findings available<br>ompletion of cause of<br>2 No |  |  |
| slcien:<br>certific<br>irector,                                                                                                                                                                                                                                                                                                    |                  | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Hospital: 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |                                  |                                                                   |                                                         |                         |                                                                                 |                                                              |                                                          |  |  |
| To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Attent this certificate has completely tilled in by the funeral director, page 2                                                                                                                                             |                  | 27. Manner of Death  1 Natural 5 Pending  2 Accident investigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 28a. Date of Injury<br>(Month, Day Year)                                                                  | 28b. Time o<br>Injury            | 4 Hursing Ho                                                      |                                                         | 28d. Describe h         | ry)                                                                             |                                                              |                                                          |  |  |
| tel or Atters atter de al Directo                                                                                                                                                                                                                                                                                                  | Certification;   | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | building, etc. (Specify)                                                                                  |                                  |                                                                   |                                                         |                         | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                                              |                                                          |  |  |
| To the Hospitel or within 24 hours atte To the Funeral Director Completely tilled in I                                                                                                                                                                                                                                             | edical           | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                  |                                                                   |                                                         |                         |                                                                                 |                                                              |                                                          |  |  |
| To the within 2 To the comple                                                                                                                                                                                                                                                                                                      | Med              | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | and manner stated.                                                                                        | 29c. License number 054288       |                                                                   |                                                         |                         | 290 Date signed (Month, Day, Year) February 25th 2008 THOSPITM CENTER           |                                                              |                                                          |  |  |
| 5                                                                                                                                                                                                                                                                                                                                  |                  | 30 Name and address of pers who co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | empleted cause of death (Itel                                                                             |                                  |                                                                   | RTHUEST                                                 | 11050                   | PIM CENTE                                                                       | a                                                            |                                                          |  |  |
| Sta<br>Regist                                                                                                                                                                                                                                                                                                                      |                  | 31. Date filed (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 32. Redistrar's Sign.                                                                                     | ature                            | Coats 1                                                           |                                                         |                         |                                                                                 |                                                              |                                                          |  |  |

DHMH 17 Rev 1/2001

3:50 AM

FEBRUARY 25,2008

UNDERKOFFIER, WILLIAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U 8 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** P Vehrencamp 2:15 PM Feb 21 200 8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner C14 Baltimore CTEMESIS It one word If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Yea Jan 25, 19 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Hours 1 M 2 X F 52 1956 Maryland Director 215-70-4825 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1√Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 6001 Bellona Avenue 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: white þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>disabled</u> none 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Charles Vehrencamp ဥ Janie Watkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ron Watkins/uncle 6307 Chesworth Road Catonsville, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other(Specify) in state 21. Signature of Funeral Service Licensee Ronal S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. B

Baltimore, MD 21201

23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by heart failure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death Immediate C se (Final disease or condition resulting in death) Due P (or as a consequence of): **Physician** mmths /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Carchosis cate has been signage 2 should b 1 Probably 4 Unknown Completed Sciques 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Anemia 1□ Yes 2₽No Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. after death.

Director: / 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or Atta 24 hours after de Funeral Directa etely filled in by t 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the Hosp within 24 hor To the Fune completely fi and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D31795 2/21/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21264 N Charles St Sute 4202 Wendy Klasz

Registrar

DHMH 17 Rev 1/2001

State

FFB 2 8 2008

31. Date filed (Month, Day, Year)



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|                                |                                                                                                                                                        |                | For Stata Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | State of Ma                                        | ryland /        | •           |                   | nt of H<br><i>te of l</i> |                        |                          | Menta                   |                            |                           | 10                       | UbZIO                                              |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------|-------------|-------------------|---------------------------|------------------------|--------------------------|-------------------------|----------------------------|---------------------------|--------------------------|----------------------------------------------------|
|                                |                                                                                                                                                        |                | Decedent's Name (First, Middle, Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | it)                                                |                 |             |                   | 10 0/ 1                   | Journ                  | '                        |                         | te of Death                |                           |                          | 3. Time of Death                                   |
| 16                             | Physici<br>/Medic                                                                                                                                      |                | ROBERT E.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | VAN                                                | DERBUR          | 2G          |                   |                           |                        |                          |                         | onth<br>bruar              |                           |                          | 4:10 p M                                           |
|                                | Examin                                                                                                                                                 | er             | 4a. Facility Name (If not institution, give HAMMONDS LANE C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                    |                 |             |                   | y, Town, or<br>oklyi      |                        |                          | h                       |                            | 4c. County                | of Death<br>Arun         | del                                                |
|                                | Funeral                                                                                                                                                | - C            | 5. Social Security Number 6. S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                    | (In yrs. last b | birthday)   | If Und            | er 1 Year                 | If Unde                | er 24 Hrs.               | 8. Da                   | te of Birth                |                           |                          | place (State or Foreign                            |
|                                | Director                                                                                                                                               |                | 244-34-6171                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Ø</b> M 2□F                                     | 80              | Yrs.        | Month             | Days                      | Hours                  | Min.                     | Aug                     | onth, Day,                 | ,1927                     | Nort                     | h Carolina                                         |
|                                | w w                                                                                                                                                    | 1              | Usual Residence of Decedent  10a. State 10b. County                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                    | 10c. City, To   | wn or Loc   | ation             |                           |                        |                          |                         |                            |                           |                          | IOd. Inside City Limits                            |
|                                | Maryl -f eho                                                                                                                                           | ē              | Maryland N/A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                    | В               | altir       | nore              | !                         |                        |                          |                         |                            |                           |                          | 1 Nes 2 No                                         |
|                                | or 28a                                                                                                                                                 | Director       | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                    |                 |             |                   | ip Code                   |                        |                          |                         | 10                         | g. Citizen of             | What Cou                 | ntry?                                              |
|                                | 23a c                                                                                                                                                  | a D            | 1 West Conway S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | treet Apt.                                         | 808             |             |                   | 212                       |                        |                          |                         |                            |                           | S.A.                     |                                                    |
|                                | er dez                                                                                                                                                 | Funeral        | 11. Marital Status                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 12. Was Decedent E<br>Armed Forces?<br>1 Tyes 2 No | ver in U.S.     | 13. W       | as Dec<br>Yes, sp | edent of Hi<br>ecify Cuba | ispanic (<br>ın, Mexic | Origin? (S<br>can, Puert | pecify You<br>to Rican, | es or No-<br>etc.)         | 14. Ra                    | ce - Ameri<br>ck, White, | can Indian,<br>etc.                                |
| 36                             | or, or                                                                                                                                                 | by             | 1 Never Married 2 Married 3 Widowed 4 Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | If Yes, Give<br>Year or Dates:                     | 0               | 1           | ☐ Yes             | 2 🗷 No                    | Specif                 | fy:                      |                         |                            | Specia                    | y: W                     | hite                                               |
| 2-0                            | s within 72 hours atter death with the Maryland<br>liene.<br>I than "naturel", or Itema 23a or 28a-f ehow<br>Itte Madical Examiner out the notified at | eted           | 15. Decedent's Ed<br>(Specify only highest gra                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | lucation                                           | 16              | Sa. Decede  | ent's Us          | ual Occupa                | ation                  | ost of wor               | rkına                   | 1                          | 6b. Kind of B             | lusiness/In              | dustry                                             |
| 121                            | within<br>iene.<br>than                                                                                                                                | Completed      | Elementary/Secondary (0-12)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | College (1-4or 5+                                  | -)              | life. D     | O NOT             | use retired               | 1)                     |                          |                         |                            | Koon'                     | a For                    | d                                                  |
| 9                              | Hyg<br>The                                                                                                                                             | ပိ             | 10<br>17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 0                                                  | 1               | Dody        | yα                | Fende                     |                        |                          |                         | , Middle, M                | aiden Sumai               |                          | u                                                  |
| <u>la</u> n                    | Mental<br>Mental<br>arked o                                                                                                                            | To B           | Lester Vander                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | burg                                               |                 |             |                   |                           | Do                     | ra Cr                    | riste                   | enbur                      | J                         |                          |                                                    |
| lary                           | and and sum                                                                                                                                            |                | 19a. Informant's Name/Relationship (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Type, Print)                                       |                 |             |                   |                           |                        |                          |                         |                            |                           |                          | <sup>Code)</sup> 21201                             |
| e, Z                           | 1 and 2<br>Health<br>em 27                                                                                                                             | 1              | Evelyn Tarbox  20a. Method of Disposition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Spouse)                                           | 20b. Place      |             |                   |                           | y Sti                  | reet                     | Apt.                    |                            | , Balt                    |                          | ryland                                             |
| nor                            | Pages<br>nent of h<br>int: If its<br>iry or of                                                                                                         |                | 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                    | сете            | tery, crem  | atory of          | other plac<br>atory       |                        | 02-2                     |                         |                            |                           |                          | Maryland                                           |
| Baltimore, Maryland 21215-0036 | 그 문원를                                                                                                                                                  |                | 21. Signature of Funeral Service Licen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                    | Dayv            | 22          | Namo              | and Addras                | se ol Eac              | nility                   |                         |                            |                           |                          |                                                    |
| Ö                              | Depa<br>fmpo<br>any ir                                                                                                                                 |                | Jan S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | yan                                                | M               | Mo          | :Cu.I<br>30 F     | ly-Po<br>ast I            | olyn:<br>Cort          | iak F<br>Aver            | unei<br>lue I           | ral Ho<br>Baltin           | ome P.,<br>nore,          | A.<br>M.ary              | land 21230                                         |
|                                |                                                                                                                                                        |                | 23a. Part1. Enter the disease, or companies of companies of the control of the co | olications that caused to be cause on each line    | the death. D    | o not ente  | r the m           | ode ol dyin               | ig, such a             | as cardiad               | c or resp               | iratory arre               | st,                       |                          | Approximate<br>Interval Between<br>Onset and Death |
| 100                            | Physician<br>/Medical                                                                                                                                  |                | Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | a Metas                                            | tatic           | - 1         | ٥٥                | ,ς                        | CB                     | nce                      |                         |                            |                           |                          |                                                    |
|                                | Examiner                                                                                                                                               |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Due to (or as a                                    | consequenc      | e of):      |                   | `                         |                        |                          |                         |                            |                           |                          |                                                    |
|                                |                                                                                                                                                        | ner            | Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | b. Due to (or as a                                 | supplied to     | is of):     |                   |                           |                        |                          |                         |                            |                           |                          |                                                    |
| V                              | and<br>transi                                                                                                                                          | Examin         | Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | c. Due to (or as a                                 |                 |             |                   |                           |                        |                          |                         |                            |                           |                          |                                                    |
| 68760,                         | ficate be executed<br>physicien and<br>is the burial-transit                                                                                           | alE            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Due to (or as a                                    | Consequenc      | ,e oi).     |                   |                           |                        |                          |                         |                            |                           |                          |                                                    |
| 687                            |                                                                                                                                                        | edlcal         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | . d                                                |                 |             |                   |                           |                        |                          |                         |                            |                           |                          | ***                                                |
| Вох                            | death certiff<br>e attending<br>id for use as                                                                                                          | an/M           | IF FEMALE:<br>23b. Was decedent pregnant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 23c. If yes, outcome of                            |                 | ıth 3□l     | Ectopic           | pregnancy                 | ,                      |                          |                         |                            | 1                         | ate of deliv             |                                                    |
| О.                             | the at                                                                                                                                                 | Physician/M    | in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4□Pregnant at t<br>9□ Unknown                      | ime ol death    | 5 🗆         | Other (           | specify)                  |                        |                          |                         |                            | , wi                      | OTILIT                   | Day Year                                           |
| <u>α</u>                       | that the dened by the a                                                                                                                                |                | Part II. Other significant conditions of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ontributing to death bu                            | t not resulting | j in the un | derlying          | cause give                | en in Par              | rt I.                    | 2                       | 3e. Did tob                | acco use cor              | tribute to               | he cause of death?                                 |
| rds                            | law requires t<br>as been signe<br>2 should be                                                                                                         | ed by          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                    |                 |             |                   |                           |                        |                          |                         | 1                          | s 2□No                    | 3 ☐ Pro                  | bably 4 Unknown                                    |
| 900                            | a a a                                                                                                                                                  | plet           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                    |                 |             |                   |                           |                        |                          | 24                      | 4a. Was ar                 |                           |                          | opsy findings available ompletion of cause of      |
| of Vital Records,              | The<br>ate h<br>page                                                                                                                                   | Completed      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                    |                 |             |                   |                           |                        |                          | 1 (                     | perform                    | ed?<br>No                 | death?                   | 2) No                                              |
| Vita                           | Physician:<br>this certific<br>ral director,                                                                                                           | Be             | 25. Was case relerred to medical examiner?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Hospital:                                          |                 |             |                   | Oth                       |                        |                          |                         | ck only one                |                           |                          |                                                    |
|                                |                                                                                                                                                        | . To           | 1 Yes 2 Too                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 28a. Date of Injur                                 |                 | . Time ol   | 3 🗆 1             | 28c. Injun                |                        | Nursing H                |                         |                            | nce 6 Ot<br>w injury occu |                          | fy)                                                |
| ion                            | E 2 5 2                                                                                                                                                | atlo           | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (Month, Day                                        | Year)           | Injury      | М                 |                           | k?<br>Yes 2            | □No                      |                         |                            |                           |                          |                                                    |
| Division                       | after death<br>after death<br>Director:                                                                                                                | Certification: | 3 Suicide 6 Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | e 28e. Place of Inju-<br>building, etc.            |                 | farm, stre  | et, fact          | ory, office               |                        |                          |                         | cation (Str<br>ity or Town |                           | ber or Rui               | al Route Number,                                   |
|                                | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by                                                           |                | 29a. Certifier 1 Certifying Ph                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ysician: To the best o                             | f my knowled    | ine death   | 0000              | d at the ti-              | no data                | and place                | a and di                | ie to the co               | use(s) and ~              | anner ac                 | stated                                             |
|                                | e Hospital                                                                                                                                             | edical         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | niner: On the basis of<br>and manner stat          | examination     |             |                   |                           |                        |                          |                         |                            |                           |                          |                                                    |
|                                | To the within 2 To the complet                                                                                                                         | Me             | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                    |                 |             | 2                 | 9c. Licens                |                        |                          |                         | 29                         | d. Date sign              |                          | Day, Year)                                         |
|                                | ^                                                                                                                                                      |                | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | - u                                                | .D              |             |                   | DS                        | -346                   | 07_                      |                         |                            | 2/27                      | 108                      |                                                    |
|                                | 3                                                                                                                                                      |                | 30. Name and address of person who                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                    |                 |             |                   | ا لم                      | )                      | _                        | C 1-                    | . 2                        | nain                      | WE                       | 2061                                               |
| ÷-                             | Sta                                                                                                                                                    | ate            | 31. Date filed (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                    | r's Signature   |             |                   |                           | -O.H                   | 2                        | 016                     | N IX                       | 711416                    | 4*\}_                    | 2061                                               |
|                                | Regist                                                                                                                                                 | _              | EER 2 8 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | nns   8nn                                          | 18              | do          | and .             | -                         |                        |                          |                         |                            |                           |                          |                                                    |

|            |                                                                                                                                                                                                                                                     | -              | For State                                                                         | State of Ma                                | ryland / Depa                           | artment of F<br>rtificate of a                               |                      |                                  | iene<br>eg. No.                  |                                                                 |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------|--------------------------------------------|-----------------------------------------|--------------------------------------------------------------|----------------------|----------------------------------|----------------------------------|-----------------------------------------------------------------|
|            | 100                                                                                                                                                                                                                                                 |                | Registrar  1. Decedent's Name (First, Middle, Last)                               |                                            |                                         |                                                              |                      | 2. Date of Deat                  | h 20                             | 3. Time of Death                                                |
|            | Physicia<br>/Medic                                                                                                                                                                                                                                  | an<br>al       |                                                                                   | JAMES                                      | HAROLD                                  | VALENT                                                       |                      | Feb. 21                          |                                  | 12:00 P M                                                       |
|            | Éxamin                                                                                                                                                                                                                                              | er             | 4a. Facility Name (If not institution, give st                                    |                                            |                                         | 4b. City, Town, o Baltin                                     | r Location of Death  | 1                                | 4c. County of D                  |                                                                 |
| - 30       |                                                                                                                                                                                                                                                     |                | 1721 Patapsco St                                                                  |                                            | (In yrs. last birthday)                 | If Under 1 Year                                              |                      | 8. Date of Birth                 | 1 9                              |                                                                 |
| b          | Funeral<br>Director                                                                                                                                                                                                                                 |                |                                                                                   | M 2□F                                      | 89 Yrs.                                 | Months Days                                                  | Hours Min.           | (Month, Day, Aug 3,              | Year)<br>1918                    | Birthplace (State or Foreign<br>Country)<br>Maryland            |
|            | olion produktion                                                                                                                                                                                                                                    |                | Usual Residence of Decedent                                                       |                                            | 40a Cib. Tourn or la                    | andian.                                                      |                      |                                  |                                  | 10d Incide City Limits                                          |
|            | arylar<br>show<br>d at                                                                                                                                                                                                                              | _              | Maryland N/A                                                                      |                                            | 10c. City, Town or Lo                   | Baltimore                                                    | 0                    |                                  |                                  | 10d. Inside City Limits 1 ☑Yes 2 ☐ No                           |
|            | the Mi                                                                                                                                                                                                                                              | Director       | 10e. Street and Number                                                            |                                            |                                         | 10f. Zip Code                                                |                      | 1                                | 0g. Citizen of Wha               |                                                                 |
|            | with sa or the r                                                                                                                                                                                                                                    | Ö              |                                                                                   | itapsco S                                  | treet                                   | 101. 2.10 0000                                               | 21                   | 230                              | USA                              |                                                                 |
|            | death<br>ms 23                                                                                                                                                                                                                                      | Funeral        |                                                                                   | 2. Was Decedent E                          |                                         | Was Decedent of H<br>If Yes, specify Cub                     |                      |                                  | 14. Race - A                     | American Indian,                                                |
| 9          | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>he Medical Examiner must be notifled at                                                                                                      | Ē              | 1 Never Married 2 Married                                                         | Armed Forces? 1 ☐ Yes 2 🕱 N If Yes, Give   | 0                                       | 1 ☐ Yes 2 ☑ No                                               | Specify:             | o racan, etc.)                   | Specify:                         | White, etc.                                                     |
| 933        | ours<br>ural",                                                                                                                                                                                                                                      | d by           | 3 X Widowed 4 □ Divorced                                                          | Year or Dates:                             |                                         |                                                              |                      |                                  | 16b. Kind of Busine              | White                                                           |
| 15         | n 72 h<br>"natu                                                                                                                                                                                                                                     | lete           | 15. Decedent's Educ<br>(Specify only highest grade                                | completed)                                 | (Give                                   | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | during most of word) |                                  | TOD. KING OF BUSIN               | ess/maustry                                                     |
| 21215-0036 | withi<br>jene.<br>r than<br>the M                                                                                                                                                                                                                   | Completed      | Elementary/Secondary (0-12)                                                       | College (1-4or 5-                          | +)                                      | chinist                                                      |                      |                                  | Md. Cup                          | Factory                                                         |
|            | s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. the Marylan sitem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | Be C           | 17. Father's Name (First, Middle, Last)                                           |                                            |                                         |                                                              | 18. Mother's Nan     | ne (First, Middle, I             | Maiden Surname)                  |                                                                 |
| Maryland   | should be fand Mental Barked of umarked of                                                                                                                                                                                                          | To             | Daniel                                                                            | Valentin                                   |                                         |                                                              | Nellie               |                                  |                                  |                                                                 |
| lar        | 12 sh<br>h and<br>r is m<br>raum                                                                                                                                                                                                                    |                | 19a. Informant's Name/Relationship (Typ                                           |                                            | 1                                       | ng Address (Street                                           |                      |                                  |                                  |                                                                 |
|            | s 1 and 2<br>of Health a<br>item 27 is<br>other trai                                                                                                                                                                                                | -              | Rhonda A. Valentine 20a. Method of Disposition                                    | e (Granda                                  | 20b Place of Dispo                      | nsition (Name of                                             | i                    | #204 L1<br>Date                  | nthicum,<br>20c. Location - City | Md . 21090<br>y or Town, State                                  |
| nor        | Pages<br>nent of I<br>ant: If its<br>ury or o                                                                                                                                                                                                       |                | 1 X Burial 2 □ Cremation 3 □ Re<br>4 □ Donation 5 □ Other (Specify)               | emoval from State                          |                                         | matory or other pla<br>11 Cemete                             |                      | /08                              | Baltimore                        | e, Maryland                                                     |
| Baltimore, | 교본원들                                                                                                                                                                                                                                                |                | 21. Signature of Fune Service License                                             | e Kevin                                    | E Ecker 2                               | 2 Name and Addre                                             | ess of Facility      | Funeral                          | Home PA                          |                                                                 |
| Ä          | permi<br>Depar<br>Impor<br>any ir                                                                                                                                                                                                                   |                | 1/62                                                                              |                                            | 111                                     | 130 E. Fo                                                    | ort Ave              | Balto.,                          | Md. 212                          |                                                                 |
|            |                                                                                                                                                                                                                                                     |                | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one | cations that caused<br>e cause on each lin | the death. Do not en<br>e.              | ter the mode of dyi                                          | ng, such as cardia   | c or respiratory arr             | est,                             | Approximate<br>Interval Between<br>Onset and Death              |
| 1          | Physician                                                                                                                                                                                                                                           |                | Immediate Cause (Final disease or condition resulting in death)                   | MYOU                                       | audi                                    | al I                                                         | nfal                 | chau                             |                                  | areday                                                          |
| 1          | /Medical<br>Examiner                                                                                                                                                                                                                                |                | resulting in death)                                                               | Due to (ras                                | a consequence of):                      | arte                                                         | VU T                 | sisea                            | ce                               | 12 44 5                                                         |
|            |                                                                                                                                                                                                                                                     | e              | Sequentially list conditions, if any, leading to immediate                        | Due to (or as                              | a consequence o ):                      | arre                                                         | 1                    | 31000                            | 00                               |                                                                 |
| J          | cuted id ansit                                                                                                                                                                                                                                      | Examine        | cause. Enter Underlying Cause (Disease or injury that initiated events            |                                            |                                         |                                                              |                      |                                  |                                  | 10                                                              |
| ó          | icate be executed<br>physician and<br>s the burial-transit                                                                                                                                                                                          | Ex             | resulting in death) Last                                                          | Due to (or as                              | a consequence of):                      |                                                              |                      |                                  |                                  |                                                                 |
| 68760,     | cate b                                                                                                                                                                                                                                              | edical         | d                                                                                 |                                            |                                         |                                                              |                      |                                  |                                  |                                                                 |
|            | certific<br>ding p                                                                                                                                                                                                                                  | /Me            | IF FEMALE:                                                                        | Bc. If yes, outcome                        | pf pregnancy                            |                                                              |                      |                                  | 23d. Date of                     | of delivery                                                     |
| Box        | death certifics<br>e attending ph<br>d for use as tl                                                                                                                                                                                                | Physician/M    | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No                  | 1 ☐Live birth<br>4 ☐ Pregnant at           | 2 ☐ Fetal death 3                       | □Ectopic pregnanc<br>□ Other (s <i>pecify)</i> _             | су                   |                                  | Month                            |                                                                 |
| 0          |                                                                                                                                                                                                                                                     | hys            | 9 ☐ Unknown                                                                       | 9□Unknown                                  |                                         |                                                              |                      |                                  |                                  |                                                                 |
| S, P       | requires that the<br>leen signed by th<br>hould be detache                                                                                                                                                                                          | þ              | Part II. Other significant conditions con                                         | tributing to death bu                      | ut not resulting in the u               | underlying cause gi                                          | ven in Part I.       | 23e. Did to                      |                                  | ute to the cause of death?  Probably 4 Unknown                  |
| Record     | w requires t<br>been signe<br>should be o                                                                                                                                                                                                           | Completed      |                                                                                   |                                            |                                         |                                                              | -                    |                                  |                                  |                                                                 |
| Rec        | has<br>has                                                                                                                                                                                                                                          | mpl            |                                                                                   |                                            |                                         |                                                              |                      | 24a. Was a<br>autop<br>perfor    | sy pric<br>med? dea              | re autopsy findings available or to completion of cause of ath? |
| <u>a</u>   |                                                                                                                                                                                                                                                     |                | 25. Was case referred to medical                                                  |                                            |                                         |                                                              | 26 Place of De       | 1□ Yes<br>ath <i>Check onl o</i> |                                  | Yes 2 No                                                        |
| Vital      | Physician:<br>this certific                                                                                                                                                                                                                         | o Be           | examiner?                                                                         | ospital:<br>1 ☐ Inpatie                    | nt 2 ☐ ER/Outpatie                      | ent 3 DOA Oti                                                | hor:                 | /                                | ence 6 Other                     | (Specify)                                                       |
| 10         |                                                                                                                                                                                                                                                     | 1              | 27. Mann of Death                                                                 | 28a. Date of Inju<br>(Month, Day           | ry 28b. Time                            | of 28c. Inju                                                 |                      | 1                                | ow injury occurred               |                                                                 |
| Sior       | Attending<br>r death.<br>ector: After<br>by the fune                                                                                                                                                                                                | atio           | 1 Matural 5 Pending investigation                                                 |                                            |                                         | M 1                                                          | ]Yes 2 ☐ No          |                                  |                                  |                                                                 |
| Division   | or Atter de Directe in by t                                                                                                                                                                                                                         | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined                                           | 28e. Place of inju-<br>building, etc       | ury - At home, farm, st<br>c. (Specify) | treet, factory, office                                       |                      | 28f. Location (S<br>City or Tow  |                                  | or Rural Route Number,                                          |
|            | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu                                                                                                                          |                | 29a. Certifier 1 Certifying Phys                                                  | ician: To the best                         | of my knowledge, dea                    | ath occurred at the t                                        | time, date and place | e, and due to the                | cause(s) and mann                | ier as stated.                                                  |
|            | ie Hos<br>n 24 h<br>ie Fun<br>letely                                                                                                                                                                                                                | Medical        | (Check only 2   Medical Examinations)                                             | ner: On the basis of and manner sta        | f examination and/or i                  | nvestigation, in my                                          | opinion, death occ   | urred at the time,               | date and place, and              | d due to the cause(s)                                           |
|            | To the within 2 To the comple                                                                                                                                                                                                                       | Me             | 29b. Signature and title of certifier                                             | 1000/                                      | 2000                                    | 29c. Licen                                                   | se number            |                                  | 29d. Date signed (               | Month, Day, Year)                                               |
|            | 1.                                                                                                                                                                                                                                                  |                | 14/10 XC                                                                          | m                                          |                                         | 1) (                                                         | (2103                |                                  | 0/1                              | 400                                                             |
|            | H                                                                                                                                                                                                                                                   |                | 30. Name and address of person who co                                             | mpleted cause of d                         | eath (Item 23a) (Type                   | Print) (- ()                                                 | St Fr                | xt a                             | lle 1                            | ND 21232                                                        |
|            |                                                                                                                                                                                                                                                     | nto-           | 31. Date filed (Month, Day, Year)                                                 | 32. Aggistr                                | ar's Signature                          | 7, 00                                                        | 0, , 0               | 01                               |                                  |                                                                 |
|            | Sta                                                                                                                                                                                                                                                 | ne             | ,                                                                                 |                                            | 14 24                                   | 1 .                                                          |                      |                                  |                                  |                                                                 |

Registrar

State of Maryland / Department of Health and Mental Hygiene: 06220 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** February 21,2008 6:30 A. George W. Vogt /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore N/A Emerald Estates Assisted Living 9. Birthplece (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, March 10, 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 219-03-6957 1 € M 2 □ F 89 Maryland Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h Count r than "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at N/A Baltimore Maryland 1√ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3855 Greenspring Avenue 21211 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ☐Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 3√☐ No Specify: Specify. White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Decunation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, It a Me Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Handyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Unknown Wagner George W. Vogt 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 41268 Baltimore Maryland 21203 19a. Informant's Name/Relationship (Type, Print) Beverly Turk/ Attorney Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Parkwood Cemetery Baltimore Maryland 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/26/08 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road Baltimore Maryland 21214 RO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SVITZ3DL **Physician** /Medical Due to (or as a consequence ol) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and a attending physicien and for use as the burial-transit death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s has autopsy performed? certificate 2 No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P this After this funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending Natural 5 Pending 2 🗌 No thin 24 hours after death.

the Funeral Diractor: A moletely filled in by the fu death. 1 ☐ Yes 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fitte of certifier 2 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVEN &JE ARK 32 Registrar's Signature 31. Date liled (Month, Day, Year) State FEB 2 8 2008 Registrar

|                     |                                                                                                                                                                                                             |                | For<br>State<br>Registrar                                                                                                         | State of Ma                                     | iryiand                                      |                            | artment of F<br>rtificate of             |                                         |                                            | Hygier<br>Reg. i              |                                | - 0 1                                          |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------|----------------------------|------------------------------------------|-----------------------------------------|--------------------------------------------|-------------------------------|--------------------------------|------------------------------------------------|
| *                   | 414                                                                                                                                                                                                         |                | Decedent's Name (First, Middle, La.                                                                                               | st)                                             |                                              |                            |                                          |                                         | 2. Date                                    | of Death                      | 2008                           | 3 Time of Death                                |
| 26                  | Physicia<br>/Medic                                                                                                                                                                                          |                | THOMAS A. WAGI                                                                                                                    | VER                                             |                                              |                            |                                          |                                         | EBF                                        | "UARY                         | 25, 200                        | 8 1:30F M                                      |
|                     | Examin                                                                                                                                                                                                      | And in other   | 4a. Facility Name (If not institution, giv<br>Saint Joseph                                                                        | e street and number)<br>Medical                 | Cent                                         | er                         | 4b. City, Town, o                        |                                         | of Death<br>OWSON                          |                               | 4c. County of Dea<br>Bal       | timore                                         |
|                     | Funeral<br>Director                                                                                                                                                                                         |                | 212-20-3044                                                                                                                       | IXM 2□F                                         | (In yrs. la                                  | st birthday)<br>Yrs.       | If Under 1 Year<br>Months Days           | If Under<br>Hours                       | Min. (Mor                                  | of Birth<br>oth, Day, Yea     |                                | thplace (State or Foreign<br>buntry)<br>RYLAND |
|                     | and w                                                                                                                                                                                                       |                | Usual Residence of Decedent  10a. State 10b. County                                                                               |                                                 | 10c. City,                                   | Town or Lo                 | cation                                   |                                         |                                            |                               |                                | 10d. Inside City Limits                        |
|                     | Maryl<br>-f sho<br>fied at                                                                                                                                                                                  | tor            | MD BALTIMOR                                                                                                                       | RE                                              |                                              | TOWS                       | ON                                       |                                         |                                            |                               |                                | 1 □Yes 2 No                                    |
|                     | th the                                                                                                                                                                                                      | Director       | 10e. Street and Number                                                                                                            |                                                 |                                              |                            | 10f. Zip Code                            |                                         |                                            | 10g.                          | Citizen of What Co             | ountry?                                        |
|                     | 23a c                                                                                                                                                                                                       |                | 911 DULANEY VALLE                                                                                                                 | EY COURT A                                      | APT.                                         | 1                          | 2120                                     |                                         |                                            | į                             | USA                            |                                                |
|                     | er dea<br>Items                                                                                                                                                                                             | Funeral        | 11. Marital Status                                                                                                                | 12. Was Decedent E<br>Armed Forces?             |                                              | 13.                        | Was Decedent of F<br>If Yes, specify Cub | Hispanic Ori<br>an, Mexica              | rigin? (Specify Yes<br>ın, Puerto Rican, e | or No-<br>tc.)                | 14. Race - Ame<br>Black, White |                                                |
| 36                  | be filed within 72 hours after death with the Maryland ttal Hygiene. In a train, or ttems 23a or 28a-f show dother than "natural", or ttems 23a or 28a-f show event, the Med a Examiner must be notified at | by F           | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced                                                                            | 1 X Yes 2 □ N<br>If Yes, Give<br>Year or Dates: | KORE                                         | AN                         | 1 ☐ Yes 2 🗓 No                           | Specify:                                | :                                          |                               | Specify: WI                    | HITE                                           |
| 2                   | 72 hou<br>natura<br>Ileal E                                                                                                                                                                                 | sted           | 15. Decedent's Education (Specify only highest gra                                                                                | ducation                                        |                                              | 16a. Deced                 | dent's Usual Occup                       | pation<br>during mos                    | st of working                              | 16b                           | . Kind of Business             | /Industry                                      |
| 2                   | ne.<br>han "i                                                                                                                                                                                               | Completed      | Elementary/Secondary (0-12)                                                                                                       | College (1-4or 5                                | +)                                           | life.                      | kind of work done<br>DO NOT use retire   | d)                                      | or or working                              |                               | DIJIT DING                     |                                                |
| ,<br>0              | filed w<br>Hygie<br>ther t                                                                                                                                                                                  |                | 10TH GRADE  <br>17. Father's Name (First, Middle, Last                                                                            | )                                               |                                              | SECI                       | JRITY GUA                                |                                         | er's Name (First, I                        |                               | BUILDING<br>den Surname)       |                                                |
| Maryland 21215-0036 |                                                                                                                                                                                                             | To Be          | HARRY WAGNER                                                                                                                      |                                                 |                                              |                            |                                          | AN                                      | INA MORAN                                  | Ī                             |                                |                                                |
| ary                 | " = m =                                                                                                                                                                                                     | _              | 19a. Informant's Name/Relationship (                                                                                              | Type. Print)                                    |                                              | 19b. Mailir                | ng Address (Street                       | and Numb                                | er or Rural Route                          | Number, Cit                   | ty or Town, State,             | Zip Code)                                      |
|                     | and 2:<br>Health arm 27 is<br>her trau                                                                                                                                                                      |                | CAROLE W. LOCHTE                                                                                                                  | SISTER                                          | 20h Bla                                      |                            | HARDWICK<br>sition (Name of              | ROAD                                    | TOWSON Date                                |                               | 21286                          | Town Chat-                                     |
| 0                   | Pages 1<br>nent of H<br>int: If ite                                                                                                                                                                         |                | 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □                                                                           |                                                 | cei                                          | metery, crei               | natory or other pla<br>MEM PAR           |                                         | 2/28/200                                   |                               | Location - City or             |                                                |
| Baltimore,          |                                                                                                                                                                                                             |                | 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lices                                                            |                                                 |                                              |                            |                                          |                                         |                                            |                               |                                | HOME, P.A.                                     |
| ä                   | permit. Departimontany Inj                                                                                                                                                                                  |                | 19                                                                                                                                |                                                 |                                              |                            |                                          |                                         | VEN BLVD.                                  |                               | SON, MD                        | 21286                                          |
|                     |                                                                                                                                                                                                             |                | 23 Part1. Enter the disease, or conshock, or heart failure. List only                                                             | cations that caused one cause on each lin       | the death.                                   | Do not ent                 | er the mode of dyi                       | ng, such as                             | s cardiac or respira                       | atory arrest,                 |                                | Approximate<br>Interval Between                |
|                     | Physician                                                                                                                                                                                                   |                | Immediate Cause (Final disease or condition resulting in death)                                                                   | a. PERFOR                                       | ATE                                          | ) BOW                      | EL                                       |                                         |                                            |                               |                                | Onset and Death                                |
|                     | /Medical<br>Examiner                                                                                                                                                                                        |                | resulting in death)                                                                                                               | Due to (or as a                                 |                                              |                            | MINAL M                                  | FTAS                                    | TOSES                                      |                               |                                |                                                |
| ,                   | 1. <del>1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1</del>                                                                                                                                                      | ier            | Sequentially list conditions, it any, leading to immediate                                                                        | b. Due to (or as a                              |                                              |                            |                                          | 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 | o I I mer bada cor                         |                               |                                |                                                |
| /                   | cuted<br>nd<br>ransit                                                                                                                                                                                       | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |                                                 |                                              |                            | Y CARCI                                  | NOMA                                    |                                            |                               |                                |                                                |
| 60,                 | ificate be executed<br>g physician and<br>as the burial-transit                                                                                                                                             | al Ex          | resulting in death) Last                                                                                                          | Due to (or as a                                 | a conseque                                   | ence of):                  |                                          |                                         |                                            |                               |                                |                                                |
| 68760,              | rificate I<br>ng physi<br>as the b                                                                                                                                                                          | edical         |                                                                                                                                   | _d                                              |                                              |                            |                                          |                                         |                                            |                               |                                |                                                |
| ×                   |                                                                                                                                                                                                             |                | IF FEMALE:<br>23b. Was decedent pregnant                                                                                          | 23c. If yes, outcome 1 ☐ Live birth             |                                              |                            | ∃Ectopic pregnand                        | 70. f                                   |                                            |                               | 23d. Date of de                | livery                                         |
| O.<br>B             | The law requires that the death cer<br>ate has been signed by the attendir<br>bage 2 should be detached for use                                                                                             | Physician/IV   | in the past 12 months? 1 ☐ Yes 2 ☐ No                                                                                             | 4☐Pregnant at                                   |                                              |                            | Other (specify)                          | -y<br>                                  |                                            |                               | Month                          | Day Year                                       |
| ۵.                  | res that the de<br>signed by the a<br>be detached t                                                                                                                                                         | Phy            | 9 ☐Unknown  Part II. Other significant conditions                                                                                 | contributing to death bu                        | ıt not resul                                 | tina in the u              | nderlyina cause aiv                      | ven in Part I                           | I. 23e                                     | . Did tobaco                  | co use contribute t            | o the cause of death?                          |
| Records,            | uires t<br>signe<br>Id be o                                                                                                                                                                                 | d by           |                                                                                                                                   |                                                 |                                              | <b>3</b>                   |                                          |                                         |                                            | 1 🗌 Yes                       | 2 <b>⊠</b> No 3□P              | robably 4 Unknown                              |
| Ö                   | tw require<br>s been signal                                                                                                                                                                                 | lete           |                                                                                                                                   |                                                 |                                              |                            |                                          | ***                                     | 248                                        | ı. Was an                     | 24b. Were a                    | utopsy findings available                      |
|                     | The lay<br>ate has<br>bage 2                                                                                                                                                                                | Completed      |                                                                                                                                   | ····                                            |                                              |                            |                                          |                                         | 1                                          | autopsy<br>performed<br>Yes 2 | ? death?                       | completion of cause of s 2 📈 No                |
| Vita                | Physician: The la rithis certificate has ral director, page 2                                                                                                                                               | Be C           | 25. Was case referred to medical examiner?                                                                                        |                                                 |                                              |                            | 1                                        |                                         | e of Death (Check                          |                               |                                |                                                |
|                     | Attending Physician: r death. ector: After this certific by the funeral director,                                                                                                                           | 2              | 1 ☐ Yes 2 S No<br>27. Manner of Death                                                                                             | Hospital: 1 Inpatie                             |                                              | R/Outpatier<br>28b. Time o | 00 20/1                                  |                                         |                                            |                               | e 6 □Other (Spe                | ecify)                                         |
| O                   | ling<br>Afte<br>fune                                                                                                                                                                                        | tion           | 1 Natural 5 Pending 2 Accident investigatio                                                                                       | (Month, Day                                     |                                              | Injury                     | Wo                                       | rk?<br>]Yes 2.[[                        |                                            | scribe now ii                 | njary occurred                 |                                                |
| Division or         | l or Attencafter death<br>Director:                                                                                                                                                                         | Certification: | 3 Suicide 6 Could not b                                                                                                           | e 280 Place of init                             | iry - At hon<br>c. <i>(Sp</i> ec <i>ify)</i> | ne, farm, str              | reet, factory, office                    |                                         |                                            | ation (Street<br>or Town, S   |                                | Rural Route Number,                            |
|                     | To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b                                                                                                                       |                | 29a. Certifier Certifying Pl                                                                                                      | nysician: To the best of                        | of my know                                   | vledge, deat               | h occurred at the ti                     | ime. date a                             | and place, and due                         | to the cause                  | e(s) and manner a              | s stated.                                      |
|                     | To the Hospital within 24 hours a To the Funeral I completely filled                                                                                                                                        | edical         |                                                                                                                                   | miner: On the basis of<br>and manner sta        | examinati                                    |                            |                                          |                                         |                                            |                               |                                |                                                |
|                     | To the within To the Comp                                                                                                                                                                                   | Me             | 29b. Signature and little of certified                                                                                            | PM                                              | 0                                            |                            | 29c. Licens                              | se number                               |                                            | 29d.                          | Date signed (Mon               | h, Day, Year)                                  |
| )                   | 6x1                                                                                                                                                                                                         |                | 1 (milly                                                                                                                          | tow III                                         | VC                                           |                            | D24                                      | 234                                     |                                            |                               | 4(2)                           | 08                                             |
| 7                   | ro.                                                                                                                                                                                                         |                | 30. Name and address of person who                                                                                                |                                                 |                                              |                            |                                          | 1 1 2000 3000 4 -                       | E 3 Jul Ami + 2 ·                          | m 6 1 m                       |                                |                                                |
|                     | Sta                                                                                                                                                                                                         | te             | 31. Date filed (Month, Day, Year)                                                                                                 | 32 Registra                                     | OSLE<br>ar's Signati                         |                            | IVE. TO                                  | WSON                                    | , MARYL                                    | HND.                          | 21204                          |                                                |
|                     | Registr                                                                                                                                                                                                     |                | FFR 2 8 20                                                                                                                        | 08 6                                            | 20                                           | - Ana                      | et I                                     |                                         |                                            |                               |                                |                                                |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10:35 AM EMBER L. WILLIAMS FEBLUARY 26 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore
Under 1 Year | If Under 24 Hrs.
onths | Days | Hours | Min. Samaritan N/A If Under 1 Year Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Yrs 215-10-6354 8/2/1915 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 X No BALTIMORE PARKVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8809 WOLVERTON ROAD 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) YEARS INSURANCE SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ISAAC OTTO MINA FURRY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FORREST WILLIAMS/SON 8809 WOLVERTON RD. BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OAKLAWN CEMETERY 2/29/2008 FASTPOINT, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. 21286 TOWSON. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEVERE SEPSIS 2 DAYS. disease or condition resulting in death) Due to (or as a consequence of): PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FAILURE 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an autopsy 2 No 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 10 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

/Medical Examiner Box P.O. Records, Division or Vital or Attending To the Hospital

physician and is the burial-transit as signed by the attending nse page 2 s has After

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

ö items 23a

"natural", or

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Department of Health ar Important: If Item 27 Is any Injury or other trau

**Physician** 

12 should be filed w h and Mental Hygier 7 Is marked other tl

Maryland 21215-0036

Baltimore,

the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

Examine

Physician/Medical

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Completed

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Certification:

Medical

MD

within 24 hours arter occ...
To the Funeral Director: Aft

25. Was case referred to medical examiner? 1 Tyes

27. Manner of Death 1 Natural

2 Accident 3 ☐ Suicide 4 ☐ Homicide

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier eh oup

D 006 1789. FEBRUARY, 26, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOT LOCA PAVEN BLUDBALTINGRE, MD 21239. LORATINE OKSAI-AWUAH

State Registrar 31. Date filed (Month, Day, Year)





State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day February 24, 2008 1428 hrs Medical Examiner CHARLIE MALLORY WILLIAMS 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Baltimore** VA Hospital N/A If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Foreign GEORGIA Months Days Hours Min Director 253-44-0517 1X M 2 Yrs 2/4/1937 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 X Yes 2 No N/A MD BALTIMORE CITY death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 813 NORTH CENTRAL AVENUE 21202 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces? 1 Never Married 2 Married 1X Yes 2 If Yes, Give Year KOREA hours after 4 X Divorced 1 Yes 2 X No specify: Specify: BLACK ۵ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) I Mental Hygiene. s marked other than "n lic event, the Medic I E College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene. Baltimore, MD 21215-0036 2 YEARS 3RD OFFICER MERCHANT MARINES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å ALTO WILLIAMS WILLIE LOUISE ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLENE M. WILLIAMS/DAUGHTER 4128 KENNYGREEN CT. RANGALLSTOWN, MD 21137 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Important: 2/28/2008 CATONSVILLE, MD **Department** METRO CREMATORY, INC. Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON.MD 21286 25a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Chronic Renal Failure Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury mai inmated events resulting in death) Last Due to (or as a consequence of): executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day 2 past 12 months' Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ۾ Yes 2 No 3 ✔ Probably 4 Unknown σ. Hip Fracture due to fall; Hypertension Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed page Yes 2 V No certificate 26 Place of Death (Check only one) Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical æ Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 🗸 Yes ٥ No 28a. Date of Injury (Month, Day, Year Feb 9, 2008 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject fell 1 Natural 0000 hrs Yes 2 V No Director: death. Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) VA. Hospital, Baltimore, Md. determined (Specify) Hospital To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number February 28, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month 1265 PM Doris B. Wiedenhoeft February 2008 13 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death (onter Baltimore Washinton medical ANNE ARUNDEL Glen Burnic If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 □ F 73 403-38-8602 June 29 1934 Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Y∏Yes 2∏No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3851 Roland Ave. 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No white Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Reservations Sales Agent Northwest Airlines 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Booth Mary Hofer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janet Morningstar/friend 3851 Roland Ave., Balto., MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2/28/08 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21. Signature of Fune al S 22. Name and Address of Facility Michael Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Inc. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL Acute Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X,No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? /es 2 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 25 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) in Febran 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Medical Center M+)-BAITIMORE 31. Date filed (Month, Day, Year) State FEB28 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

|                |                                                                                                                                                                      |                | For State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | State of Maryland /                                                                         | ,                                      | nt of Health a                                          | nd Mental Hy                     | ygienę<br>Reg. No. 00                  | 3 06225                                              |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------|---------------------------------------------------------|----------------------------------|----------------------------------------|------------------------------------------------------|
|                |                                                                                                                                                                      |                | Registrar  1. Decedent's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                        | to or boath                                             | 2. Date of D                     | eath<br>Day Ye                         | 3. Time of Death                                     |
|                | Physici<br>/Medio                                                                                                                                                    | cal            | Madi Son T<br>4a. Facility Name (If not institution, give s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             | V Nev                                  | v. Town, or Location of                                 | rebri                            |                                        | 08 2.20 F M                                          |
|                | Examin                                                                                                                                                               | ier            | Baltimore Rehability                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ( , ,                                                                                       |                                        |                                                         | timore                           |                                        |                                                      |
|                | Funeral<br>Director                                                                                                                                                  |                | 5. Social Security Number 6. Sex                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                             | birthday) If Und<br>Yrs. Month         | er 1 Year If Under 2<br>Days Hours                      | Min. (Month, D                   |                                        | Birthplace (State or Foreign<br>Country)<br>/irginia |
|                | and * 1                                                                                                                                                              |                | Usual Residence of Decedent  10a. State 10b. County                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 10c. City, Tr                                                                               | own or Location                        |                                                         |                                  |                                        | 10d. Inside City Limits                              |
|                | Maryl                                                                                                                                                                | to             | Maryland Baltin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | more                                                                                        |                                        | Edgemere                                                |                                  |                                        | 1 □Yes 2⊠No                                          |
|                | ith the                                                                                                                                                              | Director       | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             | 10f. Z                                 | ip Code                                                 |                                  | 10g. Citizen of What                   | Country?                                             |
|                | s 23a                                                                                                                                                                | era [          | 7613 Iroquois A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Venue  12. Was Decedent Ever in U.S.                                                        | 13 Was Dec                             | 2121<br>edent of Hispanic Orig                          |                                  | United S                               | States<br>American Indian,                           |
| 36             | be filed within 72 hours after death with the Maryland Hygiene. Id other then "natural", or items 23a or 28e-f show event, the Medical Exacil at most be notified at | by Funeral     | 11. Marital Status  1 Never Married 2 Married  \$\times \times \ti | Armed Forces?  1                                                                            | If Yes, sp                             | ecify Cuban, Mexican,                                   | Puerto Rican, etc.)              |                                        | Vhite, etc.<br>White                                 |
| 2-0            | 72 hou<br>natura<br>lical                                                                                                                                            | eted           | 15. Decedent's Educ<br>(Specify only highest grade                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                             | 6a. Decedent's Us<br>(Give kind of v   | ual Occupation<br>work done during most<br>use retired) | of working                       | 16b. Kind of Busine                    | ss/Industry                                          |
| 121            | within<br>iene.<br>then "                                                                                                                                            | Completed      | Elementary/Secondary (0-12) 12 Years                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | College (1-4or 5+)                                                                          | Steelw                                 |                                                         |                                  | Steel                                  | Industry                                             |
| d 2            | should be filed withir<br>nd Mental Hygiene.<br>marked other then<br>imatic event, ILE M                                                                             | Be Co          | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | I                                                                                           | DCCCIN                                 |                                                         | 's Name (First, Middl            | le, Maiden Sumame)                     | Industry                                             |
| ylar           | 2 should be fi<br>and Mental F<br>Is marked ot<br>reumatic ever                                                                                                      | To B           | Madison D. Wa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             |                                        |                                                         | na Trimmye                       |                                        |                                                      |
|                |                                                                                                                                                                      |                | 19a. Informant's Name/Relationship (Ty) Madison D. Warner,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             | •                                      | ss (Street and Number<br>oquois Ave                     |                                  | ber, City or Town, Stat<br>ce, Marylar |                                                      |
| d'             | of Health of Health of Item 27 i                                                                                                                                     | 1              | 20a. Method of Disposition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ceme                                                                                        | e of Disposition (Netery, crematory of | ame of other place)                                     | Date                             | 20c. Location - City                   | or Town, State                                       |
| Baltimore,     | Page<br>ment o<br>ent: If<br>ury or                                                                                                                                  |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ R ☐ Donation 5 🖾 Other (Specify).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | emoval from State                                                                           | kwood Ce                               | metery                                                  | 2/25/2008                        |                                        | ore, Maryland                                        |
| Balt           | permit. Pages 1<br>Department of H<br>Importent: if Ite                                                                                                              |                | 21. Sign rure of Funeral Service License                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                        |                                                         |                                  | Dundalk,<br>Maryland 2                 |                                                      |
|                |                                                                                                                                                                      |                | 23a. Parti. Enter the disease, or compli<br>shock, or heart failure. List only on                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ne cause on each line.                                                                      | Do not enter the m                     | ode of dying, such as c                                 | ardiac or respiratory            |                                        | Approximate<br>Interval Between<br>Onset and Death   |
|                | mysician<br>/Medical                                                                                                                                                 |                | Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Due to (or as a consequence                                                                 |                                        | Dement                                                  | 10                               |                                        | 7 years                                              |
|                | Examiner                                                                                                                                                             |                | O CONTROL TO A CONTROL OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Due to (or as a consequent                                                                  | Ce or).                                |                                                         |                                  |                                        |                                                      |
|                | sit sit                                                                                                                                                              | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Due to (or as a consequent                                                                  | ce of):                                |                                                         |                                  |                                        |                                                      |
| 1              | cate be executed<br>physician and<br>the burial-transit                                                                                                              | Examiner       | that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Due to (or as a consequence                                                                 | ce of):                                |                                                         |                                  |                                        |                                                      |
| ,0928          | cate be ophysicial the buri                                                                                                                                          | dical          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | l                                                                                           |                                        |                                                         |                                  | <del></del>                            |                                                      |
|                |                                                                                                                                                                      | /Med           | IF FEMALE:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 3c. If yes, outcome of pregnancy                                                            | ,                                      |                                                         |                                  | 23d. Date of                           | delivery                                             |
| .О. Вох        | that the death certific<br>led by the attending p<br>detached for use as                                                                                             | Physician/Me   | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1 Live birth 2 Fetal dead 4 Pregnant at time of death 9 Unknown                             | ath 3 ☐Ectopic                         |                                                         |                                  | Month                                  | Day Year                                             |
| rds, P.        | 8 5 8                                                                                                                                                                | by             | Part II. Other significant conditions con                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | tributing to death but not resultin                                                         | ng in the underlying                   | cause given in Part I.                                  |                                  |                                        | te to the cause of death?  Probably 4 Unknown        |
| Vital Records, | The law requir<br>ate has been si<br>page 2 should                                                                                                                   | Completed      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             |                                        |                                                         | 24a. Wa<br>aut<br>per<br>1 □ Yes | opsy prior<br>formed deat              |                                                      |
| /ital          | ilcien: Th<br>certificate<br>rector, pag                                                                                                                             | Bec            | 25. Was case referred to medical examiner?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | I                                                                                           |                                        |                                                         | of Death (Check only             | one)                                   |                                                      |
| ō              | Phys<br>rthis<br>ral di                                                                                                                                              | . To           | 1 Yes 2 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             | Outpatient 3 1                         | OOA Other: 4 Nur.<br>28c. Injury at<br>Work?            |                                  | sidence 6 Other (                      | Specify)                                             |
| ion            | Attending I<br>or death.<br>ector: After<br>by the funer                                                                                                             | ation          | 1 Natural 5 Pending 2 Accident investigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 28a. Date of Injury<br>(Month, Day Year)                                                    | Injury M                               | Work?<br>1 □ Yes 2 □ N                                  | lo                               |                                        |                                                      |
| Division       | 호플릇드                                                                                                                                                                 | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 28e. Place of Injury - At home building, etc. (Specify)                                     | , farm, street, fact                   | ory, office                                             |                                  | (Street and Number o<br>own, State)    | r Rural Route Number,                                |
|                | To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by                                                                         | cai            | (Check only 2 Medical Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | sician: To the best of my knowled<br>ner: On the basis of examination<br>and manner stated. | and/or investigati                     | on, in my opinion, death                                | n occurred at the time           | e, date and place, and                 | due to the cause(s)                                  |
|                | To th<br>withir<br>To th<br>comp                                                                                                                                     | Me             | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4440                                                                                        | 2                                      | 9c. License number                                      | Lick                             | 29d. Date signed (M                    | ionth, Day, Year)                                    |
| )              | $L_{A}$                                                                                                                                                              |                | > Vingle win                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Loon)                                                                                       |                                        | y00325                                                  | 48                               | tebruary                               | 21,2008                                              |
|                | 1041                                                                                                                                                                 |                | 30. Name and address of person who co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | mpleted cause of death (Item 23                                                             | Ba) (Type, Print)<br>OV HA G           | reene Str                                               | eet bal                          | timore,                                | Maryland                                             |
|                | Sta<br>Registr                                                                                                                                                       | ate<br>rar     | 29b. Signature and title of certifier  VILLO  30. Name and address of person who co  VILLO  31. Date filed (Month, Day, Year)  FEB 2 8 200                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 32 Aegistrar's Signature                                                                    | ANS.                                   | 7                                                       |                                  |                                        |                                                      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Carolyn Sue Wingate 9:00 P M February 24, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Center Westminster Carroll Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 □ M 2 🗓 F Yrs. Director 24,1943 219-40-8602 64 Auq. Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show "natural", or items 23a or 28a-f shov idical Examiner must be notified at 1 ☐ Yes 2 No Director Finksburg Maryland Carroll 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2437 Appaloosa Way 21048 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ğ Specify: 3 ☐ Widowed 4 € Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 Years Homemaker other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If item 27 is marked ott any lijuy or other traumatic ever once. and Mental မ Arthur Talkington Nelma Bunch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2437 Appaloosa Way Terri L. McMichael (Daughter) Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State of Faith Cem. 4 ☐ Donation 5 ☐ Other (Specify) Gdns. 2/28/2008 Baltimore, Maryland 21. Sun Ture of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OCONDIZI **Physician** tours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 sl 24a. Was an autopsy performed? Yes 2 No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral c 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury s after 05... rai Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760

filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely f and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Du ( 1005994 25,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 8 2008 State Registrar

State of Maryland / Department of Health and Mental Hygiene

|                     |                                                                                                                                                                                                                                                                                                   |                     | 1 - State Amend 4b & 4c                                                                                                                          | , perMD,g877 3                                                                       | 5/5/08 TT                                           | Cer                | tificate of l                                           | Death                                                  | R                                       | eg. No. 2     | 008                                | -06                                 | 227                       |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------|---------------------------------------------------------|--------------------------------------------------------|-----------------------------------------|---------------|------------------------------------|-------------------------------------|---------------------------|
| 40                  | Physici                                                                                                                                                                                                                                                                                           | an                  | 1. Decedent's Name (First, Middle,                                                                                                               | ,                                                                                    |                                                     |                    |                                                         |                                                        | 2. Date of Deal<br>Month                | Day           | Year                               | 3. Time o                           | or Death -                |
|                     | /Medic                                                                                                                                                                                                                                                                                            |                     | Carl Milton Zor                                                                                                                                  |                                                                                      |                                                     |                    |                                                         |                                                        | Feb 23,                                 |               |                                    | 3:08                                | a "                       |
| ) "                 | Examin                                                                                                                                                                                                                                                                                            | er                  | 4a. Facility Name (If not institution,                                                                                                           | give street and number)                                                              |                                                     | 3                  | 4b. City, Town, or Towson                               | Location of Death                                      |                                         |               | nty of Deat                        |                                     |                           |
|                     |                                                                                                                                                                                                                                                                                                   |                     | Gilchrist                                                                                                                                        |                                                                                      |                                                     |                    | Seven                                                   | <del>Valleys</del>                                     | T ===                                   | You           |                                    | altimore                            |                           |
|                     | Funeral<br>Director                                                                                                                                                                                                                                                                               |                     | 218-40-6917                                                                                                                                      | 11XIM 2□ F                                                                           | ge (In yrs. last bi                                 | Yrs.               | If Under 1 Year<br>Months Days                          | If Under 24 Hrs. Hours Min.                            | 8. Date of Birth (Month, Day)           | Year)         | 9. Birt<br>Co                      | hplace (State<br>untry)<br>MD       | or Foreign                |
|                     | aryland<br>show<br>dat                                                                                                                                                                                                                                                                            | _                   | Usual Residence of Decedent  10a. State 10b. County                                                                                              |                                                                                      | 10c. City, Tov                                      |                    |                                                         |                                                        |                                         |               |                                    | 10d. Inside (                       | City Limits               |
|                     | Ba-f                                                                                                                                                                                                                                                                                              | ctc                 | PA York                                                                                                                                          |                                                                                      | Seven                                               | Val                |                                                         |                                                        |                                         |               |                                    |                                     |                           |
|                     | or 2                                                                                                                                                                                                                                                                                              | P.                  | 10e. Street and Number                                                                                                                           |                                                                                      |                                                     |                    | 10f. Zip Code                                           |                                                        | 1                                       | 0g. Citizen   | of What Co                         | untry?                              |                           |
|                     | ath w                                                                                                                                                                                                                                                                                             | <u>ra</u>           | 7654 Player Blvd                                                                                                                                 |                                                                                      |                                                     |                    | 17360                                                   |                                                        |                                         | USA           |                                    |                                     |                           |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral Director | 11. Marital Status  1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced                                                                        | 12. Was Decedent<br>Armed Forces?<br>d 1 X Yes 2 ☐<br>If Yes, Give<br>Year or Dates: | ?                                                   |                    | Vas Decedent of H<br>i Yes, specify Cuba<br>☐ Yes 2X No | ispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)        |               | Black, White                       | rican Indian,<br>e, etc.            |                           |
| ŏ                   | 2 hou                                                                                                                                                                                                                                                                                             | pel                 | 15. Decedent's                                                                                                                                   | Education                                                                            | 168                                                 | a. Deced           | ent's Usual Occup                                       | ation                                                  | . 1                                     | 16b. Kind of  |                                    |                                     |                           |
| 75                  | in 73<br>n "n<br>Medi                                                                                                                                                                                                                                                                             | ple                 | (Specify only highest<br>Elementary/Secondary (0-12)                                                                                             | grade completed)  College (1-4or 9                                                   | 5.1                                                 | (Give i<br>life. L | kind of work done o<br>DO NOT use retired               | during most of work<br>()                              | ring                                    |               |                                    |                                     |                           |
| 212                 | with<br>giene<br>r tha                                                                                                                                                                                                                                                                            | Completed by        | 12                                                                                                                                               | College (1-40)                                                                       |                                                     | elf-               | Employed                                                |                                                        |                                         | Centr         | al Oi                              | 1 Comp                              | any                       |
| ğ                   | othe<br>ent,                                                                                                                                                                                                                                                                                      | Be C                | 17. Father's Name (First, Middle, L                                                                                                              | ast)                                                                                 | •                                                   |                    |                                                         | 18. Mother's Nam                                       | e (First, Middle,                       | Maiden Surr   | name)                              |                                     |                           |
| a                   | ld be<br>lenta<br><b>ked</b><br>ic ev                                                                                                                                                                                                                                                             | To B                | Carl Bernard Zo                                                                                                                                  | cn                                                                                   |                                                     |                    |                                                         | Dorothy                                                | Marian 1                                | [dzi          |                                    |                                     |                           |
| ary.                | shound M                                                                                                                                                                                                                                                                                          | -                   | 19a. Informant's Name/Relationshi                                                                                                                | p (Type. Print)                                                                      | 19                                                  | b. Mailin          | g Address (Street                                       | and Number or Ru                                       | al Route Numbe                          | r, City or To | vn, State, 2                       | Zip Code)                           |                           |
| ž                   | nd 2<br>alth a<br>27 is<br>r tra                                                                                                                                                                                                                                                                  |                     | Donna J. Zorn/W                                                                                                                                  | ife                                                                                  | 7.                                                  | 654                | Player B                                                | lvd. Sev                                               | en Valle                                | evs P         | A 173                              | 60                                  |                           |
| ā,                  | s 1 a<br>f Hea<br>ftem<br>othe                                                                                                                                                                                                                                                                    |                     | 20a. Method of Disposition                                                                                                                       |                                                                                      |                                                     |                    | sition (Name of<br>natory or other plac                 |                                                        |                                         |               |                                    | Town, State                         |                           |
| Baltimore,          | ages<br>ent of<br>rt: If I                                                                                                                                                                                                                                                                        |                     | 1 ☑ Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other ( <i>Sp</i>                                                                                   |                                                                                      | '                                                   |                    |                                                         | 1                                                      | 7-2008                                  | Do1+          | imore                              | MD                                  |                           |
| ₫                   | artme                                                                                                                                                                                                                                                                                             |                     | 21. Signature of Funeral Service L                                                                                                               |                                                                                      | Garde                                               |                    | of Faith  Name and Addre                                |                                                        | 7-2000  <br>chimunek                    |               |                                    |                                     | С                         |
| Ba                  | Dep<br>Imp                                                                                                                                                                                                                                                                                        |                     | If the                                                                                                                                           | 8                                                                                    |                                                     | _                  | 9705 Bela                                               | ir Rd N                                                | ottingha                                | m MD          | 2123                               | 6                                   |                           |
|                     | Physician<br>/Medical                                                                                                                                                                                                                                                                             |                     | 23a. Part1. Enter the disease, or o<br>shock, or heart failure. List of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | nly one cause on each li                                                             | d the death. Do                                     | _                  | er the mode of dyir                                     |                                                        | or respiratory ari                      | est,          |                                    | Approxim<br>Interval B<br>Onset and | d Death                   |
|                     | Examiner                                                                                                                                                                                                                                                                                          | 70                  | Sequentially list conditions,                                                                                                                    | b                                                                                    | a consequence                                       |                    |                                                         |                                                        |                                         |               |                                    |                                     |                           |
|                     | ted<br>1sit                                                                                                                                                                                                                                                                                       | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                      | 540 10 (0.40                                                                         | o a comboquano                                      | 0.,.               |                                                         |                                                        |                                         |               | 5                                  |                                     |                           |
|                     | icate be executed<br>physician and<br>s the burial-transit                                                                                                                                                                                                                                        | xar                 | that initiated events<br>resulting in death) Last                                                                                                | c<br>Due to (or as                                                                   | a consequence                                       | e of):             |                                                         |                                                        |                                         |               |                                    |                                     |                           |
| 68760,              | be e<br>iician<br>buria                                                                                                                                                                                                                                                                           | le l                | į                                                                                                                                                |                                                                                      |                                                     |                    |                                                         |                                                        |                                         |               |                                    |                                     |                           |
| 387                 | icate<br>phys<br>s the                                                                                                                                                                                                                                                                            | dic                 |                                                                                                                                                  | d                                                                                    |                                                     |                    |                                                         |                                                        |                                         |               |                                    |                                     |                           |
| .O. Box (           | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit                                                                                                                                | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                                          |                                                                                      | e pf pregnancy<br>2 ∏ Fetal dea<br>at time of death |                    | Ectopic pregnancy Other (specify)                       | /                                                      |                                         | 23d.          | Date of de<br>Month                | livery<br>Day                       | Year                      |
| Д.                  | that i<br>ed by<br>detac                                                                                                                                                                                                                                                                          | 유                   | Part II. Other significant conditio                                                                                                              | ns contributing to death t                                                           | but not resulting                                   | in the ur          | nderlying cause giv                                     | en in Part I.                                          | 23e. Did to                             | bacco use o   | ontribute t                        | o the cause o                       | of death?                 |
| ords                | w requires that<br>s been signed I<br>should be det                                                                                                                                                                                                                                               | ted by              |                                                                                                                                                  |                                                                                      |                                                     |                    |                                                         |                                                        | 1 🗆 Y                                   | es 2 N        | o 3□P                              | robably 4 [                         | Unknown                   |
| Records,            | The law i                                                                                                                                                                                                                                                                                         | Completed           |                                                                                                                                                  |                                                                                      |                                                     |                    |                                                         |                                                        | 24a. Was a<br>autop<br>perfor<br>1□ Yes |               | tb. Were a prior to death? 1 ☐ Yes | utopsy finding<br>completion o      | s available<br>f cause of |
| ta                  |                                                                                                                                                                                                                                                                                                   |                     | 25. Was case referred to medical                                                                                                                 |                                                                                      |                                                     |                    |                                                         | 26. Place of Dea                                       |                                         |               |                                    |                                     |                           |
| >                   |                                                                                                                                                                                                                                                                                                   | To Be               | examiner?<br>1 ☐ Yes 2 ☐ No                                                                                                                      | Hospital: 1 ☐ Inpati                                                                 | ient 2 ☐ ER/C                                       | Outpatien          | t 3 DOA Oth                                             |                                                        | ome 5 Resid                             |               | Other (Spe                         | ecify) ho                           | spi'ce                    |
| Division or Vital   | Attending Physic death. ector: After this by the funeral di                                                                                                                                                                                                                                       |                     | 27. Manner of Death  1 Natural 5 Pending investig.                                                                                               |                                                                                      | . Time of<br>Injury                                 | Wo                 |                                                         | 28d. Describe h                                        |                                         |               |                                    | -                                   |                           |
| Divis               | To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral                                                                                                                                                               | Certification:      | 3 ☐ Suicide 6 ☐ Could n<br>4 ☐ Homicide determi                                                                                                  | 20e. Place of III                                                                    | njury - At home,<br>etc. (Specify)                  | farm, str          | eet, factory, office                                    |                                                        | 28f. Location (5<br>City or Tox         |               | umber or F                         | tural Route N                       | umber,                    |
|                     | ne Hospit<br>n 24 hour.<br>ne Funere                                                                                                                                                                                                                                                              | Medical C           |                                                                                                                                                  | Physician: To the best<br>examiner: On the basis<br>and manners                      | of examination a                                    |                    |                                                         |                                                        |                                         |               |                                    |                                     | e(s)                      |
|                     | To th<br>Withii<br>To th                                                                                                                                                                                                                                                                          | Me                  | 29b. Signature and title of certifier                                                                                                            |                                                                                      |                                                     |                    | 29c. Licens                                             | e number                                               |                                         |               |                                    | th, Day, Year                       |                           |
| )                   |                                                                                                                                                                                                                                                                                                   |                     | Mel W                                                                                                                                            | (00                                                                                  | l                                                   |                    | Door                                                    | 51926                                                  |                                         | Feloru        | cery                               | 24,20                               | 30                        |
| 18                  | 3+1                                                                                                                                                                                                                                                                                               |                     | 30. Name and address of person of the lear M. C.                                                                                                 | who completed cause of                                                               | death (Item 23a                                     | (Type,             | Print)<br>Charlos                                       | St. PPS                                                | Ball                                    | more          | ر درو                              | 24,200                              | 404                       |
| i.                  | Sta<br>Regist                                                                                                                                                                                                                                                                                     |                     | 31. Date filed (Month, Day, Year)                                                                                                                |                                                                                      | trar's Signature                                    |                    |                                                         | ,                                                      |                                         |               |                                    |                                     |                           |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 13:01 pM 21 Edna Alban 2008 Fe bruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Semusitan Good hospita If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 K F Days 76 Baltinore, MD 312-26-6062 **Director** 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Paltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced white Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>altimore</u> 17. Father's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Surname) To Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HlDan-20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 25/08 Dubney Valley Mem Garders 2 hed BALTIMOTE KD 21234 21. Signature of Funeral Evans Funeral Chapel 23a. Part1. Enter the dise shock, or heart failure cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest te cause on each line. Immediate Cause (Final disease or condition resulting in death) failure Physician Kenal /Medical Due to (or s a consequence of): Examiner one day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending properties for use as SS IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖪 No Day 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 | Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **2** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be within 24 hours after dear To the Funeral Directo completely filled in by the 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

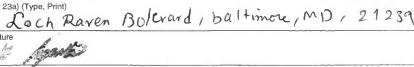
State Registrar

31. Date filed (Month, Day, Year)

2008 FEB

30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print)





Res 000

02/21/08

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

|                     |                                                                                                                                                                                                                                                                                                   | ,              |                                                                                                                                                                            | Certificate of Death                                                                              | Reg.                                                | 4000                                            | 06229                                              |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------|----------------------------------------------------|
| 92                  | Physici                                                                                                                                                                                                                                                                                           | an             | 1. Decedent's Name (First, Middle, Last)                                                                                                                                   |                                                                                                   | 2. Date of Death<br>Month<br>02/25                  | Pay o o Year                                    | 3. Time of Death                                   |
|                     | /Medic                                                                                                                                                                                                                                                                                            | cal            | Marie Anna Anderson  4a. Facility Name (If not institution, give street and number)                                                                                        | 4b. City, Town, or Location of Dea                                                                |                                                     | 4c. County of Death                             | 7:00 P M                                           |
| 7                   | Examir                                                                                                                                                                                                                                                                                            | ier            | Hospice of the Chesapeake                                                                                                                                                  | Linthicum                                                                                         |                                                     | Anne Aru                                        | ndel                                               |
| 7-1                 | Funeral                                                                                                                                                                                                                                                                                           |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthe                                                                                                               | Months Dave Hours Min                                                                             | 8. Date of Birth<br>(Month, Day, Ye                 | 9. Birthpl<br>ear) Coun                         | ace (State or Foreign<br>try)                      |
| (c)                 | Director                                                                                                                                                                                                                                                                                          |                | 215-40-7567 1 M 236F 67 Yr Usual Residence of Decedent                                                                                                                     | S.                                                                                                | 04/21/1                                             | 010                                             | land                                               |
|                     | yland<br>how<br>at                                                                                                                                                                                                                                                                                |                | 10a. State 10b. County 10c. City, Town of                                                                                                                                  | r Location                                                                                        |                                                     | 10                                              | Od. Inside City Limits                             |
|                     | ne Mau<br>8a-f sl<br>ptiffed                                                                                                                                                                                                                                                                      | Director       |                                                                                                                                                                            | Burnie                                                                                            |                                                     |                                                 | 1 ☐ Yes 2 No                                       |
|                     | with the                                                                                                                                                                                                                                                                                          | Dire           | 10e. Street and Number                                                                                                                                                     | 10f. Zip Code<br>21060                                                                            | 10g.                                                | U.S.A.                                          | try?                                               |
|                     | death<br>ms 23                                                                                                                                                                                                                                                                                    | Funeral        | 7357 Ridgewater Court, Apt. 20  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?                                                                            | 13. Was Decedent of Hispanic Origin? (<br>If Yes, specify Cuban, Mexican, Pue                     | Specify Yes or No-                                  | 14. Race - America                              |                                                    |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | þ              | 1 ☐ Never Married 2 ☐ Married  1 ☐ Ves 2 Mo of f Yes, Give  3 Midowed 4 ☐ Divorced Year or Dates:                                                                          | If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 <b>Y</b> No Specify:                                | rto Rican, etc.)                                    | Specify: Wh                                     | ite                                                |
| 5-0                 | 72 hc<br>"natul<br>dical                                                                                                                                                                                                                                                                          | Completed      | 15. Decedent's Education (Specify only highest grade completed) (6                                                                                                         | ecedent's Usual Occupation<br>Rive kind of work done during most of wo<br>fe. DO NOT use retired) | orking 16t                                          | . Kind of Business/Ind                          | lustry                                             |
| 121                 | within<br>ene.<br>than '                                                                                                                                                                                                                                                                          | pmc            | Elementary/Secondary (0-12)   College (1-4or 5+)                                                                                                                           | omemaker                                                                                          | I .                                                 | Own Home                                        |                                                    |
| 102                 | e filed y<br>al Hygie<br>other i                                                                                                                                                                                                                                                                  | Be             | 17. Father's Name (First, Middle, Last)                                                                                                                                    |                                                                                                   | me (First, Middle, Mai                              |                                                 | -                                                  |
| ylar                | Ments<br>Ments<br>arked<br>arlc ev                                                                                                                                                                                                                                                                | 일              | John Richard Chaney                                                                                                                                                        |                                                                                                   | nie Lorra                                           |                                                 |                                                    |
| Mar                 | d 2 shu<br>h and<br>7 Is m<br>traum                                                                                                                                                                                                                                                               |                |                                                                                                                                                                            | Address (Street and Number or F                                                                   | •                                                   |                                                 | ,                                                  |
| <u>ة</u>            | tem 2                                                                                                                                                                                                                                                                                             |                |                                                                                                                                                                            | 9 Sutton Drive, isposition (Name of crematory or other place)                                     |                                                     | c. Location - City or To                        |                                                    |
| altimore,           | Pages<br>nent of<br>int: If i                                                                                                                                                                                                                                                                     |                | I Burial 2 Defination 3 Hemoval from State                                                                                                                                 | Hill Cem 02                                                                                       | /29/08 B                                            | altimore                                        | , MD                                               |
| alti                | permit. Departm Importa any Inju                                                                                                                                                                                                                                                                  |                | 21. Signature of Euneral Service Licensee                                                                                                                                  | 22. Name and Address of Facility G                                                                | .J.Gonce                                            | Funeral                                         | Home, PA                                           |
| <b>8</b>            | 205 20                                                                                                                                                                                                                                                                                            | Н              | Muf Ra-                                                                                                                                                                    | 169 Riviera Dr                                                                                    |                                                     |                                                 |                                                    |
| 3                   |                                                                                                                                                                                                                                                                                                   |                | 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final            |                                                                                                   | ac or respiratory arrest,                           |                                                 | Approximate<br>Interval Between<br>Onset and Death |
|                     | Physician /Medical                                                                                                                                                                                                                                                                                |                | disease or condition resulting in death)  a. Due to (or as a consequence of)                                                                                               | Cancer                                                                                            |                                                     | 1                                               | 4 Month                                            |
| E                   | Examiner                                                                                                                                                                                                                                                                                          |                | Sequentially list conditions b.                                                                                                                                            |                                                                                                   |                                                     |                                                 |                                                    |
| 7                   | ed sit                                                                                                                                                                                                                                                                                            | niner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                                                |                                                                                                   |                                                     |                                                 |                                                    |
|                     | ertificate be executed<br>ing physician and<br>e as the burial-transit                                                                                                                                                                                                                            | Examine        | that initiated events resulting in death) Last C. Due to (or as a consequence of)                                                                                          |                                                                                                   |                                                     |                                                 |                                                    |
| 68760,              | ysicial                                                                                                                                                                                                                                                                                           |                |                                                                                                                                                                            |                                                                                                   |                                                     |                                                 |                                                    |
|                     | ertifica<br>ing ph<br>e as th                                                                                                                                                                                                                                                                     | Medical        | IF FEMALE:                                                                                                                                                                 |                                                                                                   |                                                     |                                                 |                                                    |
| Вох                 | death ce<br>e attendii<br>d for use                                                                                                                                                                                                                                                               | Physician/     | 23b. Was decedent pregnant in the past 12 months?                                                                                                                          | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)                                                         |                                                     | 23d. Date of delive<br>Month                    | ry<br>Day Year                                     |
| P.0                 | 0 0 0                                                                                                                                                                                                                                                                                             | hysid          | 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown                                                                                                                     | Outer (specify)                                                                                   |                                                     |                                                 |                                                    |
|                     | ss that<br>gned k                                                                                                                                                                                                                                                                                 | by P           | Part II. Other significant conditions contributing to death but not resulting in the                                                                                       | e underlying cause given in Part I.                                                               | 23e. Did tobac                                      | co use contribute to th                         | e cause of death?                                  |
| ord                 | law requires that the<br>as been signed by th<br>2 should be detache                                                                                                                                                                                                                              |                |                                                                                                                                                                            |                                                                                                   | 1 ☐ Yes                                             | 2No 3□ Prob                                     | ably 4 □Unknown                                    |
| 3ec                 | has by                                                                                                                                                                                                                                                                                            | Completed      |                                                                                                                                                                            |                                                                                                   | 24a. Was an autopsy                                 | prior to cor                                    | osy findings available<br>npletion of cause of     |
| <u>Ea</u>           | ate<br>pag                                                                                                                                                                                                                                                                                        |                | 25. Was case referred to medical                                                                                                                                           | 00 81 (8                                                                                          | performed                                           | No 1 ☐ Yes                                      | 2□ No                                              |
| or Vital Records,   | Physician:<br>r this certific<br>ral director,                                                                                                                                                                                                                                                    | To Be          | examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp                                                                                                                      | 0.1                                                                                               | ath <i>(Check only orle)</i><br>Home 5 ☐ Residenc   | e 6 □Other (Specify                             | /)                                                 |
| 0 U                 | ding Phy. h. After thi                                                                                                                                                                                                                                                                            |                | 27. Manner of Dath 1 X Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Inju                                                                                      | ne of 28c. Injury at                                                                              | 28d. Describe how                                   |                                                 | ,                                                  |
| Division            | Attending<br>r death.<br>ector: After<br>by the funer                                                                                                                                                                                                                                             | catio          | 2 Accident investigation 3 Suicide 6 Could not be 280 Ricco of injury. At home form                                                                                        | M 1 Yes 2 No                                                                                      | 296 Location (Ctma                                  | t and Number or Dum                             | I Doute Alimbas                                    |
| <u>&gt;</u>         | after after I Direct                                                                                                                                                                                                                                                                              | Certification: | 4 Homicide determined building, etc. (Specify)                                                                                                                             | , street, lactory, office                                                                         | City or Town, S                                     | t and Number or Rura<br>State)                  | r noute Number,                                    |
|                     | To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the                                                                                                                                                                                        | edical C       | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, (Check only one)  Medical Examiner: On the basis of examination and/and manner stated. | leath occurred at the time, date and placer investigation, in my opinion, death occ               | ee, and due to the caus<br>curred at the time, date | se(s) and manner as si<br>and place, and due to | ated. the cause(s)                                 |
|                     | To the within 2 To the complet                                                                                                                                                                                                                                                                    | Med            | 29b. Signature and title of certifier                                                                                                                                      | 29c. License number                                                                               | 29d.                                                | Date signed (Month,                             | Day, Year)                                         |
|                     |                                                                                                                                                                                                                                                                                                   |                | (drannan M.D                                                                                                                                                               | D 39505                                                                                           | Fe                                                  | bruary                                          | 26,2008                                            |
|                     | y                                                                                                                                                                                                                                                                                                 |                | 30. Name and address of person who completed cause of death (Item 23a) (Ty                                                                                                 | D 39505<br>Hospital Dr.                                                                           | Glan Run                                            | nie mi                                          | 5.21061                                            |
|                     | Sta                                                                                                                                                                                                                                                                                               | te             | 31. Date filed (Month, Day, Year) 32. Registrar's Signature                                                                                                                | HOZDILOR DI.                                                                                      | ,                                                   | ., .                                            |                                                    |
|                     | Pagist                                                                                                                                                                                                                                                                                            | _              | EED 9 0 2000 A                                                                                                                                                             | f. N.                                                                                             |                                                     |                                                 |                                                    |

DHMH 17 Rev 1/2001

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death y 26, 2008 **Physician** Buchanan Bramer burary /Medical 4b. City, Town, or Location of Death 4c. County of Death (If not institution, give street and number) Examiner Square osedalp If Under 24 Hrs. Year) 1929 (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🗙 F 220-24-5091 79 Maryland Director February 4, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. "Hardrain" is marked other than "natural", or items 23a or 28a-f show Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injuny or other traumatic event, the Medical Examiner must be notified at Baltimore Dundalk 1 ☐ Yes 2X No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2760 Kirkleigh Road 21222 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Paint Company Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Bramer Hedwig Ida Garlichs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2760 Kirkleigh Road, Dundalk, Maryland Frank Buchanan Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State 27, 2008 Baltimore City, MD. 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Signature of uneral Service Connective Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or compleshoek, or heart failure. List only o c, tations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is cause on each line. Immediate Cause (Final eno Carci **Physician** 6+ astatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 3□ DOA ဥ 2 ER/Outpatient this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by

Box 68760,

Division or Vital Records, P.O. i or Attending Fafter death. Director: within 24 hours a Hospital

4 Homicide

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 💢 Certifying/Rhysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square William Registrar Signature 31. Date filed (Month, Day, Year)

Registrar

|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | -              | _ FOI                                                                                                                                    | partment of Health and Menta<br>ertificate of Death                                            |                                  | _ / 11111            | 3 06232                                              |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------|----------------------|------------------------------------------------------|
| _           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | riegistiai                                                                                                                               |                                                                                                | Reg. I                           | No.                  | 2 Time of Death                                      |
|             | Physicia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | 1. Decedent's Name (First, Middle, Last)                                                                                                 | M. M.                                                                                          |                                  | Day Year             | 3. Time of Death                                     |
|             | /Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | al .           |                                                                                                                                          |                                                                                                |                                  | 22 08                | 0755M                                                |
|             | Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | er             | 4a. Facility Name (If not institution, give street and number)                                                                           | 4b. City, Town, or Location of Death                                                           |                                  | 4c. County of Dea    | th                                                   |
| 1.2         | 186                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                | 13100 Forest Drive                                                                                                                       | Bowie  V) If Under 1 Year   If Under 24 Hrs.   8, Da                                           | to of Dieth                      |                      | Georges                                              |
|             | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda                                                                            | Months Days Hours Min.                                                                         | ate of Birth<br>fonth, Day, Yei  | ar) Co               | hplace (State or Foreign<br>buntry)                  |
|             | Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | -              | 579-24-4854 Vsual Residence of Decedent                                                                                                  |                                                                                                | 05/25/                           | /1922 R              | I                                                    |
|             | and<br>t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ŀ              | 10a. State 10b. County 10c. City, Town or                                                                                                | Location                                                                                       |                                  |                      | 10d. Inside City Limits                              |
|             | Mary<br>f she                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ō              | MD Prince Georges Bowie                                                                                                                  |                                                                                                |                                  |                      | 1 XYes 2 No                                          |
|             | the<br>28a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Director       | 10e. Street and Number                                                                                                                   | 10f. Zip Code                                                                                  | 10g.                             | Citizen of What Co   | ountry?                                              |
|             | with<br>3a or<br>1 be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | 13100 Forest Drive                                                                                                                       | 20715-                                                                                         |                                  | USA                  |                                                      |
|             | death with the Maryland rms 23a or 28a-f show r must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Funeral        |                                                                                                                                          | 3. Was Decedent of Hispanic Origin? (Specify Y<br>If Yes, specify Cuban, Mexican, Puerto Rican |                                  | 14. Race - Ame       |                                                      |
| _           | fter of riter of rite | Ē              | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No                                                                                             |                                                                                                | , etc.)                          | Black, Whit          | e, etc.                                              |
| 3           | urs a al'', o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | þ              | 3 Midowed 4 Divorced If Yes, Give Year or Dates:                                                                                         | 1 ☐ Yes 2 ☑ No Specify:                                                                        |                                  | Specify:             | hite                                                 |
| Ž           | 2 ho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Completed      | 15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi                                                              | cedent's Usual Occupation                                                                      | 16b                              | . Kind of Business   | /Industry                                            |
| 212-0036    | hin 7<br>an "r<br>Med                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ple            | Elementary/Secondary (0-12) College (1-4or 5+)                                                                                           | ive kind of work done during most of working b. DO NOT use retired)                            | .   '                            | Governme             | nt                                                   |
| V           | gien<br>gien<br>th:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | NO.            | 4 Ad                                                                                                                                     | ministrative Assistan                                                                          | <u> </u>                         |                      |                                                      |
| p           | be filed within 72 hours after death with the Marylan ital Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at event,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Be (           | 17. Father's Name (First, Middle, Last)                                                                                                  | 18. Mother's Name (Firs                                                                        | t, Middle, Maid                  | den Surname)         |                                                      |
| Ian         | should be filed within 72 hours after and Mental Hygiene. s marked other than "natural", or ite umatic event, the Medical Examine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 2              | Herbert Kimball Cummings                                                                                                                 | Gertrude I                                                                                     | illian                           | Smith                |                                                      |
| Mar         | s 1 and 2 should be filed v<br>f Health and Mental Hygie<br>item 27 Is marked other t<br>other traumatic event, tb                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | 19a. Informant's Name/Relationship (Type. Print) 19b. Ma                                                                                 | ailing Address (Street and Number or Rural Rou                                                 | te Number, Ci                    | ty or Town, State,   | Zip Code)                                            |
|             | es 1 and 2<br>of Health<br>item 27 l                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | - 1            | Fletcher, Robert L/Son-in-Law 1:                                                                                                         | 3100 Forest Drive Bowi                                                                         | e, MD                            | 20715-               |                                                      |
| Š           | of He                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | 20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □ Removal from State                                                                | sposition (Name of Date rematory or other place)                                               | 200                              | . Location - City or | Town, State                                          |
| Ĕ           | Pages<br>nent of I<br>ant: If ite<br>ury or o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                |                                                                                                                                          | ake Crematory 2/24/0                                                                           | 8   -                            | Beltsvill            | e, Maryland                                          |
| galtimore,  | permit. Pages<br>Department of<br>Important: If I<br>any Injury or once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | İ              | 21. Signature of Funeral Service Licensee  Mo0382                                                                                        | 22. Name and Address of Facility                                                               |                                  |                      |                                                      |
| n           | B L L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | Stalish Johnney                                                                                                                          | Rapp Funeral & Cremati<br>933 Gist Ave. Silver                                                 |                                  |                      | 20910-                                               |
| Н           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. | enter the mode of dying, such as cardiac or resp                                               | oiratory arrest,                 |                      | Approximate                                          |
|             | Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | Immediate Cause (Final disease or condition                                                                                              |                                                                                                | Teas                             |                      | Interval Between<br>Onset and Death                  |
|             | /Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | resulting in death)  a.  Due to (or as a consequence of):                                                                                | roundsond we                                                                                   | Leve                             |                      |                                                      |
|             | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                |                                                                                                                                          |                                                                                                |                                  |                      |                                                      |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Jer            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                              |                                                                                                |                                  |                      |                                                      |
| V           | cuted<br>id<br>ansit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Examine        | that initiated events C.                                                                                                                 |                                                                                                |                                  |                      |                                                      |
| Š           | an ar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | EX             | resulting in death) Last  Due to (or as a consequence of):                                                                               |                                                                                                |                                  |                      |                                                      |
| 8/60        | cate be executed oblysician and the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | dical          | d                                                                                                                                        |                                                                                                |                                  |                      |                                                      |
| ٥           | The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Med            | J. C.                                                                                                |                                                                                                |                                  |                      |                                                      |
| ROX         | leath certific<br>attending p<br>for use as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Physician/Me   | IF FEMALE: 23c. If yes, outcome pf pregnancy   1 □ Live birth 2 □ Fetal death                                                            | 3 □Ectopic pregnancy                                                                           |                                  | 23d. Date of de      |                                                      |
|             | deat<br>e att                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | icie           | in the past 12 months?  1  Yes 2 No 9 Unknown                                                                                            | 5 Other (specify)                                                                              |                                  | Month                | Day Year                                             |
| J<br>Ö      | at the de<br>by the a<br>tached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | hys            | 9 ☐ Unknowh • 9☐ Offictiown                                                                                                              |                                                                                                |                                  |                      |                                                      |
|             | res tha<br>signed l                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | by P           | Part II. Other significant conditions contributing to death but not resulting in the                                                     | e underlying cause given in Part I.                                                            | 23e. Did tobac                   | co use contribute    | o the cause of death?                                |
| ē           | w require<br>been sign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | pa             |                                                                                                                                          |                                                                                                | 1 Tyes                           | 2 No 3 ☐ F           | robably 4 Unknown                                    |
| Hecords,    | aw requ<br>s been<br>2 shoul                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | olet           |                                                                                                                                          | 2                                                                                              | 24a. Was an                      | 24b. Were a          | utopsy findings available                            |
|             | sician: The law<br>certificate has t<br>irector, page 2 s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Completed      |                                                                                                                                          |                                                                                                | autopsy<br>performed<br>I□ Yes 2 | d? death?            | completion of cause of s 2 \( \subseteq \text{No} \) |
| Vital       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Be C           | 25. Was case referred to medical                                                                                                         | 26. Place of Death (Che                                                                        |                                  | 10                   | 2 2 110                                              |
|             | ysici<br>is cel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0              | examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa                                                                                   | tient 3 DOA Other: 4 Nursing Home                                                              | 5 ☐ Residenc                     | e 6 Other (Sp        | ecify) DAMCHTE                                       |
| LIVISION OF | g Phys<br>er this<br>eral di                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | T:U            | 27. Manner of Death  1 Matural  28a. Date of Injury (Month, Day Year)  Inju                                                              | e of 28c. Injury at 28d. I                                                                     |                                  | injury occurred      | Horne                                                |
| ō           | th.<br>fr: Aft                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | tio            | 1 Matural 5 □ Pending (Month, Day Year) Inju<br>2 □ Accident investigation                                                               | M 1 Yes 2 No                                                                                   |                                  |                      |                                                      |
| NIS         | flor Attending Peter death. Livector: After to in by the funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ific           | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)                                                            | street, factory, office 28f. L                                                                 | ocation (Stree                   |                      | Rural Route Number,                                  |
| 5           | all or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Certification: | building, etc. (Opeany)                                                                                                                  |                                                                                                | ny or rown, c                    | , idio,              |                                                      |
|             | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, d                                                                    |                                                                                                |                                  |                      |                                                      |
|             | he Ho<br>n 24<br>he Fu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | edical         | (Check only one) 2 Medical Examiner: On the basis of examination and/one and manner stated.                                              | ii iiivesugauon, iri my opinion, death occurred at                                             | une ume, date                    | anu piace, and di    | ie to trie cause(s)                                  |
|             | To the To the To the Comp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Me             | 29b. Signature and title of certifier                                                                                                    | 29c. License number                                                                            | 29d.                             | Date signed (Moi     | nth, Day, Year)                                      |
|             | /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | Im but Telutem                                                                                                                           | 1 21438                                                                                        | 19                               | Februera.            | . L2 2008                                            |
|             | 15                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1              | 30. Name and address of person who can pleted cause of death (Item 23a) (Ty                                                              | pe, Print)                                                                                     | 7                                | y                    |                                                      |
|             | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | MICHAEL J. LOVENTAMO 445                                                                                                                 | DEFENSE HIGHWAY                                                                                | Ann                              | AROUS h              | ND 214601                                            |
|             | - Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ite            | 31. Date filed (Month, Day, Year) 32. egistrar's Signature                                                                               | marke)                                                                                         |                                  |                      |                                                      |
|             | Regist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ar             | FFB 2 9 2008 Januar Januar                                                                                                               |                                                                                                |                                  |                      |                                                      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2008 11:50 26, VOWIN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Elder care Her Haye Center GRARSIS altimore 8. Date of Birth Month, Day, Ye If Under 1 Yea If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 Months Hours 214-24-489 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location пs 23a or 28a-f show must be notified at 1 □Yes 2 No Baltimore Maryland by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Item or other traumatic event, the Medical Examiner I Black White etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. QO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) abover 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimare , MO 21222 /33 NIZCE 20b. Place of Disposition (Name of Acemetery, crematory or other pla Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ices 21. Si nature of Euneral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on fain line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregpant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 mor Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? anificant conditions Completed by 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes မ 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural 1niury within 24 hours aner ucco...

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year!

2008

MORE

use of death (Item 23a NType, Phat) 4 10

Registrar's Signature

|                                                                                                                                                                                                                                                                   |                | 1 - For<br>State<br>Registrar                                                                                                     |                          | State of Ma                                     | arylanc               |                             | artment of H<br>rtificate of I             |                                        | Mental Hy                         | giene<br>Reg. No.        | 2008                              | 06234                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------|-----------------------|-----------------------------|--------------------------------------------|----------------------------------------|-----------------------------------|--------------------------|-----------------------------------|-------------------------------|
|                                                                                                                                                                                                                                                                   | -              | Decedent's Name (First,                                                                                                           | Middle, La               | ast)                                            |                       |                             |                                            |                                        | 2. Date of De                     | eath                     |                                   | 3. Time of Death              |
| Phys<br>/Ma                                                                                                                                                                                                                                                       | ician<br>dical | Hazel                                                                                                                             |                          | Church                                          |                       |                             |                                            |                                        | Februa                            | Day                      | , 2008                            | 12:20P M                      |
| Exan                                                                                                                                                                                                                                                              |                | 4a. Facility Name (If not inst                                                                                                    | itution, giv             | ve street and number)                           |                       | -                           | 4b. City, Town, or                         | r Location of Dea                      |                                   |                          | County of Death                   | 120201                        |
|                                                                                                                                                                                                                                                                   | elen.          | 8132 Greens                                                                                                                       |                          |                                                 |                       |                             |                                            | ngs Mil                                |                                   |                          | Baltin                            | nore                          |
| Funera                                                                                                                                                                                                                                                            |                | 5. Social Security Number                                                                                                         | 6. 8                     | 4 T M 057 E                                     |                       | <i>st birthday)</i><br>Yrs. | If Under 1 Year<br>Months Days             | If Under 24 Hr<br>Hours Mir            | . (Month, D                       | rth<br>a <i>y, Year)</i> | Coui                              | place (State or Foreign ntry) |
| Directo                                                                                                                                                                                                                                                           | or             | 521-24-2745 Usual Residence of Decede                                                                                             |                          | -K                                              | 83                    | 115.                        |                                            |                                        | July 9                            | , 192                    | 24 Miss                           | issippi                       |
| /land<br>ow                                                                                                                                                                                                                                                       |                | 10a. State 10b. C                                                                                                                 |                          |                                                 | 10c. City,            | Town or Lo                  | cation                                     |                                        |                                   |                          | 1                                 | 0d. Inside City Limits        |
| Mar<br>a-f sh                                                                                                                                                                                                                                                     | 호              | MD E                                                                                                                              | alti                     | more                                            |                       | Ow:                         | ings Mill                                  | s                                      |                                   |                          |                                   | 1 ☐ Yes 2 ☐ No                |
| th the                                                                                                                                                                                                                                                            | Directo        | 10e. Street and Number                                                                                                            |                          |                                                 |                       |                             | 10f. Zip Code                              |                                        |                                   | 10g. Citiz               | en of What Cour                   | ntry?                         |
| 23a c                                                                                                                                                                                                                                                             |                | 8132 Green                                                                                                                        | spri                     | ng Valley                                       | Road                  |                             | 211                                        | 17                                     |                                   |                          | USA                               |                               |
| er dea                                                                                                                                                                                                                                                            | Funeral        | 11. Marital Status                                                                                                                |                          | 12. Was Decedent<br>Armed Forces?               |                       | 13.                         | Was Decedent of H<br>If Yes, specify Cuba  | lispanic Origin? (<br>an, Mexican, Pue | Specify Yes or Norto Rican, etc.) | 0- 1                     | 4. Race - Americ<br>Black, White, |                               |
| 36 s afte                                                                                                                                                                                                                                                         | by F           | 1 ☐ Never Married 2☐<br>3 🖫 Widowed 4 ☐ Div                                                                                       |                          | 1 ☐ Yes 2 🔯 I<br>If Yes, Give<br>Year or Dates: | No                    |                             | 1 ☐ Yes 2 📉 No                             | Specify:                               |                                   |                          | Specify:                          |                               |
| ire, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at |                |                                                                                                                                   | edent's E                |                                                 |                       | 16a. Dece                   | dent's Usual Occup                         | ation                                  |                                   | 16b Kin                  | Whi<br>nd of Business/In          |                               |
| 715<br>nin 72<br>n "na<br>Wedic                                                                                                                                                                                                                                   | Completed      | (Specify only Elementary/Secondary (0                                                                                             | highest gra              | ade completed) College (1-4or 5                 |                       | (Give<br>life.              | kind of work done of<br>DO NOT use retired | during most of wo                      | orking                            | TOB. IXII                | id 51 545/11655/111               | 20307                         |
| d with giene gr tha                                                                                                                                                                                                                                               | Ę              | Elementary/Secondary (0                                                                                                           | 12)                      | 2                                               | )+)<br>               | I                           | Homemaker                                  |                                        |                                   |                          | Own Ho                            | ome                           |
| nd<br>se file<br>al Hy<br>lothe                                                                                                                                                                                                                                   | Be             | 17. Father's Name (First, M                                                                                                       | ddle, Last               | ")                                              |                       |                             |                                            | 18. Mother's Na                        | me (First, Middle                 | e, Maiden S              | Surname)                          |                               |
| Vial                                                                                                                                                                                                                                                              | 2              | Perry Thom                                                                                                                        | as Ha                    | arper                                           |                       |                             |                                            |                                        | a Viola 1                         |                          |                                   |                               |
| Maryland 21 d 2 should be filed w tith and Mental Hygie 27 Is marked other tit                                                                                                                                                                                    |                | 19a. Informant's Name/Rela                                                                                                        |                          |                                                 |                       |                             | ng Address (Street                         |                                        |                                   |                          |                                   |                               |
| ore, M6                                                                                                                                                                                                                                                           |                | Susi L. Chur                                                                                                                      | ch                       | Daughter                                        | 20h Bis               |                             | Greenspr                                   |                                        | Ley Road                          |                          | ngs Mill                          |                               |
|                                                                                                                                                                                                                                                                   |                | 1 ☐ Burial 2 ☑ Crema                                                                                                              | tion 3                   | Removal from State                              |                       |                             | sition (Name of<br>matory or other place   | 1                                      |                                   |                          | _                                 |                               |
| it. P. sartme prtant                                                                                                                                                                                                                                              | -11            | 4 □ Donation 5 □ Ott                                                                                                              |                          |                                                 | Car                   |                             | Cremation  2. Name and Addres              |                                        | 28/08                             |                          | mpstead,                          |                               |
| baltimo permit. Page Department of important: If any Injury or                                                                                                                                                                                                    | ouce           | 100                                                                                                                               | hon                      | -MC                                             | ruk                   | -                           | Line Fune                                  |                                        |                                   |                          | istersto                          |                               |
|                                                                                                                                                                                                                                                                   | 1              | 23a. Part1. Enter the disea shock, or heart failure                                                                               | se, or com               | plications that aused                           | the death.            |                             |                                            |                                        |                                   |                          | COWII, FIL                        | Approximate Interval Between  |
| Physicia                                                                                                                                                                                                                                                          | n              | Immediate Cause (Final                                                                                                            | . List only              | one cause on each life                          | ne.<br>1 <i>01111</i> | com                         | 1                                          |                                        |                                   |                          | 1                                 | Onset and Death               |
| /Medica                                                                                                                                                                                                                                                           | _              | disease or condition resulting in death)                                                                                          | -                        | a. Due to (or as                                | a conserue            | ence of):                   | Π                                          |                                        |                                   |                          |                                   | JEHRS                         |
| Examine                                                                                                                                                                                                                                                           | r              | Convention link on diving                                                                                                         | - 8                      | b                                               |                       |                             |                                            |                                        |                                   |                          |                                   |                               |
| 70 #                                                                                                                                                                                                                                                              | ner            | Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events | J                        | Due to (or as                                   | a conseque            | ence of):                   |                                            |                                        |                                   |                          |                                   |                               |
| ecute<br>and<br>trans                                                                                                                                                                                                                                             | Examiner       | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last                                                     |                          | c                                               |                       |                             |                                            |                                        |                                   |                          |                                   |                               |
| be ex<br>cian a                                                                                                                                                                                                                                                   | E E            | , robating in death, East                                                                                                         |                          | Due to (or as                                   | a conseque            | ence of):                   |                                            |                                        |                                   |                          |                                   |                               |
| 68 / 60,<br>ficate be executed<br>physician and<br>is the burial-transit                                                                                                                                                                                          | edical         |                                                                                                                                   |                          | _d                                              |                       |                             |                                            |                                        |                                   |                          |                                   |                               |
|                                                                                                                                                                                                                                                                   | /Me            | IF FEMALE:<br>23b. Was decedent pregna                                                                                            | nt l                     | 23c. If yes, outcome                            | pf pregnan            | icy                         |                                            |                                        |                                   | ,                        | 3d. Date of delive                | 20/                           |
| death death                                                                                                                                                                                                                                                       | iciai          | in the past 12 months                                                                                                             |                          | 1□Live birth<br>4□Pregnant at                   |                       |                             | Ectopic pregnancy Other (specify)          | /                                      |                                   |                          | Month                             | Day Year                      |
| ecords, P.O. BOX law requires that the death cert as been signed by the attending 2 should be detached for use a                                                                                                                                                  | Physician/M    | 9 Unknown                                                                                                                         |                          | 9□Unknown                                       |                       |                             |                                            |                                        |                                   |                          |                                   |                               |
| S, T                                                                                                                                                                                                                                                              | by P           | Part II. Other significant co                                                                                                     | nditions                 | contributing to death b                         | ut not resul          | ting in the u               | nderlying cause giv                        | en in Part I.                          | 23e. Did                          | tobacco us               | se contribute to t                | ne cause of death?            |
| ecords, law requires t as been signe 2 should be c                                                                                                                                                                                                                |                |                                                                                                                                   |                          |                                                 |                       |                             |                                            |                                        | 1/2                               | ¥es 2□                   | No 3 Prob                         | pably 4 □Unknown              |
|                                                                                                                                                                                                                                                                   | plet           |                                                                                                                                   |                          |                                                 |                       |                             |                                            |                                        | 24a. Was                          |                          | 24b. Were auto                    | psy findings available        |
| ate T                                                                                                                                                                                                                                                             | Completed      |                                                                                                                                   |                          |                                                 |                       |                             |                                            |                                        |                                   | ormed?                   | death?<br>1 ☐ Yes                 | 2□ No                         |
| VISION OF VITAL IN Attending Physician: The relation. The ector: After this certificate by the funeral director, pag                                                                                                                                              | Be             | 25. Was case referred to me examiner?                                                                                             | edical                   | 1 1 1 2 - 1                                     |                       |                             | Low                                        |                                        | eath Check onl                    | one                      |                                   |                               |
| Physic ruthis caral direction                                                                                                                                                                                                                                     | ြို            | 1 Yes 2 No                                                                                                                        |                          | Hospital:                                       |                       |                             | t 3 DOA Oth                                | 4   Nursing                            | Home 5 Res                        |                          |                                   | y)                            |
| on or ding Phys                                                                                                                                                                                                                                                   | io             | 1 Natural 5 □ F                                                                                                                   | ending<br>vestigatio     | 28a. Date of Inju<br>(Month, Da                 |                       | 28b. Time o<br>Injury       | Wor                                        | yat<br>k?<br>Yes 2 ⊟No                 | 28d. Describe                     | now injury               | occurred                          |                               |
| INISION Or Attending after death. Director: Afte                                                                                                                                                                                                                  | fical          | 3 ☐ Suicide 6 ☐ G                                                                                                                 | ould not be<br>etermined | e 28a Place of init                             | urv - At hon          | ne, farm, str               | eet, factory, office                       | 103 2 10                               | 28f. Location                     | Street and               | f Number or Rura                  | al Route Number               |
| after after din b                                                                                                                                                                                                                                                 | Certification: | 4 Homicide                                                                                                                        | etermined                | building, et                                    | c. (Specify)          |                             | ,,                                         |                                        | City or To                        | wn, State)               |                                   | ,                             |
| spita<br>hours<br>mera<br>y fille                                                                                                                                                                                                                                 |                |                                                                                                                                   |                          | hysician: To the best                           |                       |                             |                                            |                                        |                                   |                          |                                   |                               |
| DIVISIO  To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A  completely filled in by the fu                                                                                                                                      | Medical        | one)                                                                                                                              |                          | miner: On the basis o<br>and manner sta         | ated                  |                             | -                                          |                                        |                                   |                          |                                   |                               |
| To the within To the comple                                                                                                                                                                                                                                       | Z              | 29b. Signature and title of o                                                                                                     | entifier                 | 2 7                                             |                       |                             | 29c. Licens                                | e number                               |                                   | 29d. Date                | signed (Month,                    | Day, Year)                    |
| -5                                                                                                                                                                                                                                                                |                | 1)60                                                                                                                              | 1                        | 11/1/                                           | 2                     |                             | _   D                                      | 64395                                  | 5                                 | FEBA                     | EKARY27                           | , 2008                        |
| 10                                                                                                                                                                                                                                                                |                | 30. Name and address of p                                                                                                         | erson who                | completed cause of d                            | leath (Item :         | 23a) (Type,                 | Print)                                     | 10                                     | (21.77.2                          | 16                       | ENTING.                           | MO SIDAII                     |
| 10                                                                                                                                                                                                                                                                |                | 31. Date filed (Month, Day,                                                                                                       | Vari                     | MHIV, MO                                        | 650                   | 15 N                        | CHHILL                                     | 5011                                   | 84117 4                           | 09 6                     | MUIMAE!                           | mu 4 204                      |
| S<br>Regi:                                                                                                                                                                                                                                                        | State<br>strar | 51. Date filed (Month, Day,                                                                                                       | n n n                    | 2000 SZ. Hedictr                                | aı ə əignatl          | L/                          | haile :                                    |                                        |                                   |                          |                                   |                               |
| DHMH 17 Rev                                                                                                                                                                                                                                                       | -              | <u> </u>                                                                                                                          | 5 2 9                    | ZUUD THE                                        | Sept 1                | 15                          |                                            |                                        | . ,                               |                          |                                   | Day, Year) 1, 2008 MD 21204   |

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nonth Day **Physician** 2008 10:17 PM Mary Gloria Chubb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 🗹 F 215-28-9984 04/06/1931 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If time 27 is ansked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel MD Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 638 Opel Road 21060 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No altimore, Maryland 21215-0036 þ 3 □ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Fries Elizabeth Hessler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William John Chubb/Husband 638 Opel Road, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holy Cross Cem 03/03/08 | Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 21. Signature of Emeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ancrestu Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) signed by the at d be detached for 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. Medical Certification: To 27. Manuar of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) February 27 2 29b. Signature and title of certifier 30. Name and address of person who/completed cause of death (Kem 23a) (Type, Print)

Gev vg & E. Wicks III) 301 Wuspital Drive, Gen Burnie MD

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 2 9 2008

and the

32, Registrar's Signature

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State DHMH 17 Rev 1/2001 29b. Signature and title of certifier

CHIN HONG 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RKSDOO

4940 EASTERN AVENUE BALTIMORE MID

29d. Date signed (Month, Day, Year)

2/26/08

|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 1 - For<br>State<br>Registrar                                                                   | State of Ma                                        |                                         | partment of H<br>Partificate of L               |                                |                                            | iene             | 08                    | 06237                                        |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------|-------------------------------------------------|--------------------------------|--------------------------------------------|------------------|-----------------------|----------------------------------------------|
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | Decedent's Name (First, Middle, Li                                                              | ast)                                               |                                         |                                                 |                                | 2. Date of Deat                            | h                | W                     | 3. Time of Death                             |
|                   | Physici<br>/Medio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | Pauline 1                                                                                       | ADELINE                                            | CLASI                                   | Neg.                                            |                                | Month<br>Z                                 | Day<br>27        | Year                  | 10:01 PM                                     |
|                   | Examir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                | 4a. Facility Name (If not institution, gi                                                       |                                                    | ,                                       | 4b. City, Town, or                              | Location of Death              |                                            | 4c. County       | of Death              |                                              |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | Harford M                                                                                       | 14MORIAL                                           | HOSDIZATI                               | HAVE                                            | de GRA                         | ce. no                                     | HA               | RFOR                  | ed.                                          |
|                   | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | Social Security Number 6.                                                                       | Sex 7. Age                                         | (In yrs. last birthda)                  | y) If Under 1 Year<br>Months Days               | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day,<br>Aug. 3 | Year)            | 9. Birthp<br>Coun     | lace (State or Foreign                       |
| Ш                 | Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | 220-24-1641                                                                                     | 1□M 2□ F                                           | 78 Yrs.                                 | World Suys                                      | 110013                         | Aug.3,                                     | 1929             |                       | MD                                           |
|                   | pue *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | Usual Residence of Decedent  10a. State 10b. County                                             |                                                    | 10c. City, Town or                      | Location                                        |                                |                                            |                  | 1                     | 0d. Inside City Limits                       |
|                   | lanyli<br>•ho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ក              | MD Balti                                                                                        | more                                               | · ·                                     | sex                                             |                                |                                            |                  | ,                     | 1 ☐ Yes 2 ☑ No                               |
|                   | 289-1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Director       | 10e. Street and Number                                                                          |                                                    |                                         | 10f. Zip Code                                   |                                |                                            | Og. Citizen of \ | Affice Cour           |                                              |
|                   | with or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ā              | 930 Arncliffe                                                                                   | Poad                                               |                                         |                                                 | 1                              | '                                          |                  | rviiat Cour           | uy:                                          |
|                   | leath                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | era            | 11. Marital Status                                                                              | 12. Was Decedent B                                 | ver in U.S. 13                          | 21221<br>3. Was Decedent of Hi                  |                                | ecify Yes or No-                           | USA<br>14. Bac   | e - Americ            | an Indian.                                   |
| 92                | 72 hours after death with the Maryland<br>nature!', or iteme 23a or 28e-f ehow<br>littel Examiner must be motified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | y Funeral      | 1 ☐ Never Married 2 ☐ Married                                                                   | Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give           |                                         | If Yes, specify Cuba<br>1 ☐ Yes 2 🛣 No          | in, Mexican, Puerto  Specify:  | Rican, etc.)                               |                  | ck, White,            |                                              |
| 21215-0036        | 72 hours<br>"naturel",                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | d by           | 3 ☑ Widowed 4 □ Divorced                                                                        | Year or Dates:                                     |                                         |                                                 |                                |                                            | 174              |                       |                                              |
| 7                 | - 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Completed      | 15. Decedent's 8<br>(Specify only highest g                                                     |                                                    | (Giv                                    | cedent's Usual Occupa<br>ve kind of work done o | during most of work            |                                            | 16b. Kind of B   | usiness/Ind           | dustry                                       |
| 12                | 72 - 5 30                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Ę              | Elementary/Secondary (0-12)                                                                     | College (1-4or 5-                                  | F)                                      | . <i>DO NOT use retired</i><br>nemaker          | ")                             |                                            | own h            | OMA                   |                                              |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 8th 17. Father's Name (First, Middle, Las                                                       | <i>t</i> )                                         | 1101                                    | iiciiaxci                                       | 18. Mother's Nam               | e (First Middle )                          |                  |                       |                                              |
| Maryland          | Q & D .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Be c           | Lionel Bass                                                                                     | •                                                  |                                         |                                                 |                                | ra Gre                                     |                  | ,,,,,                 |                                              |
| 2                 | should<br>nd Men<br>marke<br>umatic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ဥ              | 19a. Informant's Name/Relationship                                                              | (Type Print)                                       | 19b Ma                                  | iling Address (Street a                         |                                |                                            |                  | State Zin             | Code                                         |
| Ma                | nd 2 should alth and 27 io mu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                | Rick Clasing                                                                                    |                                                    |                                         | 2 Holcomb                                       |                                |                                            | •                |                       | ·                                            |
|                   | E E E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1              | 20a. Method of Disposition                                                                      | , 5011                                             | 20b. Place of Dis                       | position (Name of                               |                                |                                            | 20c. Location    |                       |                                              |
| ē                 | m 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                | MBurial 2 ☐ Cremation 3                                                                         |                                                    |                                         | rematory or other place<br>Hill Ceme            |                                |                                            | Balti            |                       |                                              |
| Baltimore,        | 그 돈 돈 글 .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | 4 □ Donation 5 □ Other (Special Signature of Funeral Septice Lice                               |                                                    |                                         | 22. Name and Addres                             |                                |                                            |                  |                       |                                              |
| Ba                | Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Deperm |                | 1 Kabus 7                                                                                       | en Conne                                           | eg gr                                   |                                                 | 3 (                            | 0 Mace                                     |                  |                       | co. MD<br>ex 21221                           |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 23a. Part . Enter the disease, or of shock, or heart failure. List on                           | notications that caused<br>y one cause on each lin | the death. Do not e                     | enter the mode of dyin                          | g, such as cardiac             | or respiratory arr                         | est,             |                       | Approximate<br>Interval Between              |
|                   | Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | Immediate Cause (Final disease or condition                                                     | 2/45                                               | PERCAPHE                                | ic Reso                                         | MOTAL                          | FAILO                                      | RE               |                       | Onset and Death                              |
|                   | /Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | resulting in death)                                                                             |                                                    | consequence of):                        |                                                 |                                | 4                                          |                  |                       |                                              |
|                   | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | Sequentially list ounditions                                                                    | b                                                  | OBSTRUC                                 | TIUE (                                          | (lees)                         | APREA                                      |                  |                       |                                              |
|                   | <u>ت</u> و                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying              | Due to (or as a                                    | consequence of):                        |                                                 | 4.                             |                                            |                  |                       |                                              |
|                   | and<br>and<br>trans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Vica                                            | TL Jpp                                  | 45 8-5                                          | ICATO                          | Infec                                      | TION             |                       |                                              |
| 60,               | cien a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ŵ              |                                                                                                 | Due to (or as a                                    | consequence of :                        |                                                 | 1                              |                                            |                  |                       |                                              |
| 68760,            | icate be executed<br>physicien and<br>s the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | dlcal          |                                                                                                 | d                                                  |                                         |                                                 |                                |                                            |                  | -                     |                                              |
| 9 ×               | leath certific<br>ettending pl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                | IF FEMALE:                                                                                      | 02- 16                                             |                                         |                                                 |                                |                                            |                  |                       |                                              |
| Вох               | ath c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | lan            | 23b. Was decedent pregnant in the past 12 months?                                               | 23c. If yes, outcome of<br>1 ☐ Live birth          | 2 Fetal death 3                         | B □Ectopic pregnancy                            | ,                              |                                            |                  | ite of delive<br>onth | ery<br>Day Year                              |
| o.                | the e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Physician/M    | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                                                                   | 4□Pregnant at<br>9□ Unknown                        | time of death 5                         | 5 ☐ Other (specify)                             |                                |                                            |                  |                       |                                              |
| P.0               | hat ti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                | Part II. Other significant conditions                                                           | contributing to death by                           | t not resulting in the                  | underlying cause give                           | en in Part I                   | 23e Did to                                 | hacco use con    | tribute to t          | he cause of death?                           |
| of Vital Records, | signe<br>d be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1 by           |                                                                                                 | DBSTFULTIN                                         |                                         |                                                 | 1138AS4                        | 1[]Y                                       |                  |                       | pably 4 []Unknown                            |
| Ö                 | requ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Completed      | >1                                                                                              |                                                    | 130                                     | )                                               | 0.70)76                        | -                                          |                  |                       |                                              |
| 3ec               | elaw<br>hasi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | d L            | HYPETTE                                                                                         | 7510~                                              |                                         |                                                 |                                | 24a. Was a autops perfor                   | sy               | pnor to co            | ppsy findings available mpletion of cause of |
| a<br>F            | : The licete ha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | S              | DIABETES                                                                                        | Meine                                              | >                                       |                                                 |                                | 1 Yes                                      |                  | death?<br>1 ☐ Yes     | 2□ No                                        |
| Z.                | iciar<br>certif<br>ecto                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Be             | 25. Was case referred to medical examiner?                                                      | Hospital:                                          |                                         | 100                                             | 26. Place of Dear              | th (Check only or                          | 10)              |                       |                                              |
| ot o              | Phys<br>this<br>al dir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 10             | 1 ☐ Yes 2 ☐ No 27. Manner of Death                                                              | 1 2 Inpatie                                        |                                         |                                                 | 4   Nursing H                  | ome 5 Resid                                |                  |                       | y)                                           |
| Z.                | sing<br>P.<br>After<br>funer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | o              | Natural 5 ☐ Pending                                                                             | 28a. Date of Injur<br>(Month, Day                  | Year) 28b. Time<br>Injury               | / Worl                                          |                                | 28d. Describe h                            | ow injury occur  | rred                  |                                              |
| isi               | death<br>death<br>stor:<br>the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | cat            | 2 Accident investigati 3 Suicide 6 Could not                                                    | he                                                 | *************************************** |                                                 | Yes 2 □No                      | ON Leasting (C                             | tonne and blum   | har as Due            | al Barda Miraba                              |
| Division          | or A<br>after<br>Direction by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Certification: | 4 Homicide determine                                                                            | building, etc                                      | ry - At nome, tarm,<br>. (Specify)      | street, factory, office                         |                                | City or Tow                                |                  | Der or Mura           | al Route Number,                             |
| _                 | spital<br>ours<br>parei<br>filled                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | 29a. Certifier 1 Certifying F                                                                   | Physician: To the best of                          | f my knowledge, de                      | ath occurred at the tim                         | ne date and place              | and due to the o                           | auco/e) and m    | annar as s            | tated                                        |
|                   | Hos<br>24 h<br>Fur<br>etely                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Medical        | (Check only 2 Medical Expone)                                                                   | aminer: On the basis of and manner sta             | examination and/or                      | investigation, in my o                          | pinion, death occur            | red at the time, o                         | late and place,  | and due to            | the cause(s)                                 |
|                   | To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funare! Director: After this certificate has been signed by the ettending completely illed in by the funeral director, page 2 should be detached for use as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Me             | 29b. Signature and title of certifier                                                           |                                                    |                                         | 29c. Licens                                     | e number                       | 2                                          | 29d. Date signe  | ed (Month,            | Day, Year)                                   |
|                   | . 713 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | 1                                                                                               | to L                                               | 10                                      | 1                                               | 66342                          |                                            | 2/27             | 108                   |                                              |
|                   | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | 30. Name and address of person wh                                                               |                                                    |                                         | e. Print)                                       |                                |                                            |                  |                       |                                              |
| 1                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 500 UPP812                                                                                      | CHECADEA                                           | va Dani                                 | · Pa                                            | - Air                          | un                                         | 21012            |                       |                                              |
|                   | Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ite            | 31. Date filed (Month, Day, Year)                                                               | 32. Pagistra                                       | r's Signature                           | freets )                                        | -                              | 7-17                                       |                  |                       |                                              |
|                   | Regist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | rar            | FEB29                                                                                           | 2008                                               | 40 FB 1                                 |                                                 |                                |                                            |                  |                       |                                              |

Clasing, Pauline

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vaar **Physician** 9:10 A.M Melvin M. Cole February 26 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year) 09/26/1933 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🕱 M 2 🗆 F 74 Mary land Yrs. 213 30 8467 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Arno1d Maryland Anne Arundel Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ U.S.A. 21012 1075 Short Acres Road or Items 23a Funeral deeth 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Depurment of Health and Mental Hygiene. Important: If liem 27 is marked othar than "natural", or lier any injury or other traumatic event Armed Folces: 1 Types 2 No If Yes, Give Year or Dates: Korean 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Local Union 101 Carpenter 10th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Beatrice Haines George Cole Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold, Maryland 21012 1075 Short Acres Road Mary Cole / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State MD State Veteran Cem. 03/03/2008 Crownsville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Lisensee Baltimore, Maryland 21225 4001 Ritchie Highway ramerous 234. Part1. Enter the disease of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause of pach line. Interval Between Onset and Death hly one cause on Immediate Cause (Final disease or condition resulting in death) Neumous **Physician** /Medical Due to (or as a consequence of): Lenkonio Examiner avous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit sete has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Norkepwn 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 this certificate 1 Yes 2 🗆 ours after deeth.

Neral Director: After this certifical filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 1 ☐ Yes 2 ☑No 2 ER/Outpatient 3 DOA Certification: To 1 Sepatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral 6 To the Hospital The printying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Dey, Year) of certifier 29b. Signature and 126 200 pleted cause of death (Item 23a) (Type, Print) 400 32. Ragistrar's Signature 31. Date filed (Month 2008

DHMH 17 Rev 1/2001

State

Registrar

9

08-01650 William V. Daley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 06239

|                                                                                                                                                                                                                                        |                | 1- For State<br>Registrar                                             |                                                                                                                                               | Cert             | ificate o                      | f Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |              |                                         | eg. No.         | _ 0 0        | 0 0                              | V 2 V 2     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------|-----------------------------------------|-----------------|--------------|----------------------------------|-------------|
| Physicia                                                                                                                                                                                                                               | in/            | 1. Decedent's Name (First, Middle,L.                                  |                                                                                                                                               |                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              | <ol><li>Date of Dea<br/>Month</li></ol> | Day \           | Year         | 3. Time of De                    |             |
| ledical Examin                                                                                                                                                                                                                         |                |                                                                       | Villiam Vernon Daley, IV  Facility Name (if not institution, give street and number)  4b. City, Town,  Frederick Memorial Hospital  Frederick |                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              | February                                | 26, 2008        |              | 1540 hrs                         | S           |
|                                                                                                                                                                                                                                        |                |                                                                       |                                                                                                                                               | r)               |                                | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | n of Death   |                                         | Frede           | ity of Death | 1                                |             |
|                                                                                                                                                                                                                                        |                | Frederick Memorial Hosp                                               |                                                                                                                                               |                  | - 4 In East                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | der 24Hrs.   | le Date of Ri                           |                 |              | thplace (State                   | or          |
| Funeral                                                                                                                                                                                                                                | 1              |                                                                       |                                                                                                                                               | ge (In yrs. las  | st birthday)                   | If Under 1<br>Months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |              |                                         |                 | Foreig       | gn<br>puntry)Mary                | land        |
| Director                                                                                                                                                                                                                               |                | 262–91–1948                                                           | X M 2 F                                                                                                                                       | 4.               | 3 Yr                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              | 08/25                                   | /1964           |              | untry) - 2                       |             |
| >-                                                                                                                                                                                                                                     | -              | Usual Residence of Decedent  10a, State 10b, County                   |                                                                                                                                               | 10c City 1       | Town or Loca                   | ition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |              |                                         |                 |              | 10d. Inside C                    | City Limits |
| w any                                                                                                                                                                                                                                  | - 1            | Florida Po                                                            | o1k                                                                                                                                           |                  | Lake                           | eland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |              |                                         |                 |              | 1 Yes                            |             |
| Maryland<br>28a-f show<br>d at once.                                                                                                                                                                                                   | ₽              | Maryland Freder                                                       |                                                                                                                                               | Frede            | erick                          | 10f. Zip Coo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10               |              |                                         | 10g. Citizen of | What Cou     | intry?                           |             |
| Mary<br>r 28a                                                                                                                                                                                                                          | Director       | 6726 Trail Ridge                                                      | e Dr.                                                                                                                                         |                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <sup>3</sup> 338 | 13           |                                         | , og. o         |              |                                  | I           |
| (Lef.) (C) - death with the Maryland or items 23a or 28a-f sho must be notified at once                                                                                                                                                |                | 716 North Market                                                      |                                                                                                                                               |                  | 140.14                         | 21701                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | f Hispania C     | Ingin2 / Sp  | pecify Yes or No                        | U.S.A.          | ace - Amer   | rican Indian, Bl                 | lack        |
| st he wi                                                                                                                                                                                                                               | Funeral        | 11. Marital Status  1 X Never Married 2 Marrie                        | 12. Was Decede<br>Armed Force                                                                                                                 |                  |                                | Yes, specify Co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              |                                         |                 | hite, etc.   | rodi i irodini, Di               |             |
| l (LC)<br>ter death with<br>", or items 2<br>er must be n                                                                                                                                                                              | 교              |                                                                       | 1 Yes<br>ed If Yes, Give Year                                                                                                                 | 2X No            | 1                              | Yes 2 X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | No speci         | fv:          |                                         | Speci           | fy: Whi      | te                               |             |
| rs aft                                                                                                                                                                                                                                 | <u>a</u>       | 15. Decedent's Education (Specify                                     | Lor Dates:                                                                                                                                    | ompleted)        | 16a, Decede                    | ent's Usual Occ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              | work done                               | 16b. Kind of    |              |                                  |             |
| 2 hou<br>"nat                                                                                                                                                                                                                          | mpleted        | Elementary/Secondary (0-12)                                           | College (1-4 c                                                                                                                                |                  | during r                       | most of working                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | life. DO NO      | OT use retir | red)                                    |                 |              |                                  |             |
| 36<br>thin 72<br>e.<br>than<br>edical                                                                                                                                                                                                  | 힐              | 12                                                                    |                                                                                                                                               |                  | Labore                         | er                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |              |                                         | Groce           | erv St       | tore                             | -           |
| 5-0C<br>ed wii<br>fygier<br>other                                                                                                                                                                                                      | S              | 17. Father's Name (First, Middle, La                                  | st)                                                                                                                                           |                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 18.Moth          | ner's Name   | (First, Middle,                         |                 |              | W                                |             |
| 21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural"; cevent, the Medical Examiner                                                                                                                | Be             | William Vernon                                                        | Daley, III                                                                                                                                    |                  | 53-340-015                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Cla              | ire I        | vnn Ze                                  | ller            |              |                                  |             |
| MD 21215-0036<br>2 should be filed within 72 hours after death with the Maryland<br>h and Mental Hygiene.<br>27 is marked other than "natural", or items 23a or 28a-f she<br>mair event, the Medical Examiner must be notified at once | ٥              | 19a. Informant's Name/Relationship                                    |                                                                                                                                               |                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              | Rural Route Nu                          |                 |              |                                  | 4.0         |
| MD<br>d 2 sho<br>lth and<br>n 27 is<br>numati                                                                                                                                                                                          |                | Claire Lynn Str                                                       | ickland- N                                                                                                                                    |                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              | e, Lake                                 |                 |              | 1da 338<br>r Town, State         | 313         |
|                                                                                                                                                                                                                                        |                | 20a. Method of Disposition  1 Burial 2 Cremation                      | 3 Removal from                                                                                                                                |                  | lace of Dispo<br>rematory or c | osition (Name on<br>other place)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ot cemetery,     |              | Date                                    | 200. Locali     | ion - City u | Town, State                      |             |
| MO<br>Paged<br>lent o                                                                                                                                                                                                                  |                | 4 Donation 5 Other Spec                                               |                                                                                                                                               | Bay              | view (                         | Cremato                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ry In            | c 02/        | 28/2008                                 | Balti           | more         | , Maryl                          | and         |
| Baltimore,<br>permit. Pages 1 at<br>Department of Hee<br>Important; If ite                                                                                                                                                             | 1              | 21. Signature of Funeral Service Lic                                  | ensee                                                                                                                                         |                  | 22.                            | Name and Add                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | dress of Fac     | ility Bru    | zdzinsl                                 | ki Fune         | eral H       | Home P.                          | A.          |
| <b>a</b> 52 5 5                                                                                                                                                                                                                        |                | 23a, Part I. Enter the disease, or co                                 | Je Min                                                                                                                                        | 500              | 1.                             | 407 Old                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | East             | ern A        | venue,                                  | Essex,          | Mary         | zland 2                          | 1221        |
| Physician                                                                                                                                                                                                                              |                | 23a, Part I. Enter the disease, or confailure. List only one cause on | mplications that cause<br>each line.                                                                                                          | éd the death.    | Do not enter                   | the mode of d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ying, such a     | s cardiac o  | or respiratory a                        | rrest, shock, o | r neart      | perween                          | Oliset and  |
| Medical<br>caminer                                                                                                                                                                                                                     | 1              | Immediate Cause (Final disease                                        | a. Quetiapine                                                                                                                                 |                  |                                | itoxicati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | on               |              |                                         |                 |              | De                               | eath        |
|                                                                                                                                                                                                                                        |                | or condition resulting in death)                                      | Due to (or as a cor                                                                                                                           | nsequence of     | ):                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              |                                         |                 |              |                                  |             |
|                                                                                                                                                                                                                                        | ᡖ              | Sequentially list conditions, if any, leading to immediate            | Due to (or as a cor                                                                                                                           | nsequence of     | ):                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              |                                         |                 |              |                                  |             |
|                                                                                                                                                                                                                                        | 흩              | cause. Enter Underlying Cause<br>(Disease or injury that initiated    | с                                                                                                                                             |                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              |                                         |                 |              | 29.1                             |             |
| sit od                                                                                                                                                                                                                                 | Exai           | events resulting in death) Last                                       | Due to (or as a cor                                                                                                                           | nsequence of     | ·):                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              |                                         |                 |              |                                  |             |
| 760, icate be executed physician and the burial - transit                                                                                                                                                                              | -1             | V                                                                     | d. X AMENDED 23                                                                                                                               | 27.20            | . C                            | ME - 077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2 /27 /00        | , , 1        | 0a-c,e                                  | f per           | inf g        | 3883 9-                          | 4-08 v      |
| 760,<br>cate be ex<br>physiciar<br>the burial                                                                                                                                                                                          | /Medica        | X UNPENDED                                                            |                                                                                                                                               |                  |                                | ME 88//                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 3/2//08          | amn          |                                         |                 | te of delive |                                  |             |
| , P.O. Box 68760, res that the death certificate be signed by the attending physici be detached for use as the buri                                                                                                                    | ١              | IF FEMALE:<br>23b. Was decedent pregnant in the                       | 23c. If yes, outo                                                                                                                             |                  | nancy<br>2 F                   | etal death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 3 Ecto           | opic pregna  | ancy                                    | Mon             |              | Day                              | Year        |
| Box 68<br>e death certifi<br>the attending                                                                                                                                                                                             | Physician      | past 12 months?                                                       | 4 Pregnant                                                                                                                                    | at time of de    | oth                            | Other (Specify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |              |                                         | 3               |              |                                  | 1           |
| Bo<br>e deat<br>the at<br>ed for                                                                                                                                                                                                       | hys            | 1 Yes 2 No 9 Unkno                                                    | 9 Onknown                                                                                                                                     |                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              |                                         |                 |              |                                  | 1           |
| P.O.                                                                                                                                                                                                                                   |                | Part II. Other significant condition                                  | ns contributing to de                                                                                                                         | ath but not re   | esulting in the                | underlying ca                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | use given In     | Part I.      |                                         |                 |              | to the cause of obably 4         |             |
| ires that                                                                                                                                                                                                                              | d by           |                                                                       |                                                                                                                                               |                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              |                                         |                 |              |                                  |             |
| rds<br>requires                                                                                                                                                                                                                        | Completed      |                                                                       |                                                                                                                                               |                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              |                                         | opsy            | prior to     | autopsy finding<br>completion of |             |
| ecc<br>he lav<br>te hau                                                                                                                                                                                                                | μŽ             |                                                                       | -                                                                                                                                             |                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              |                                         | formed?         | death?       |                                  | No          |
| tal Recian: The certificate ector, page                                                                                                                                                                                                |                | 25. Was case referred to medical                                      |                                                                                                                                               |                  |                                | 26.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Place of Dea     | ath (Check   | only one)                               |                 |              |                                  |             |
| Vita                                                                                                                                                                                                                                   | o Be           | examiner?<br>1 ✓ Yes 2 No                                             | Hospital: 1 Inpa                                                                                                                              | atient 2 🗸       | ER/Outpatie                    | nt 3 DOA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Other            | Nursi        | ng Home 5                               | Residence       | 6 Oth        | ier:                             |             |
| # (- 1 <u>V</u> n of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should                                                                                                   | -              | 27. Manner of Death                                                   | 28a. Date of I<br>(Month, Da                                                                                                                  | njury<br>v Year) | 28b. Time o                    | f Injury 280                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | . Injury at W    | ork?         |                                         | e how injury or |              | 1 . 1 .                          | .11         |
| – ਵੈਂੂ ਪੈਫੀ                                                                                                                                                                                                                            | Ęį             | 1 Natural 5 Pendin                                                    | found 2                                                                                                                                       |                  | found 9                        | :40 am 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Yes 2            | XX No        | pubject                                 | ingested        | arugs        | and alc                          | COUOT       |
| (V > D S S                                                                                                                                                                                                                             | fica           | 2 Accident Investig                                                   | 28e Place of                                                                                                                                  |                  |                                | reet, factory, of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | fice building    | g, etc.      | 28f. Location                           | (Street and N   | lumber or l  | Rural Route Nu<br>cet Stree      | umber, City |
| Divis pital or At ours after d eral Direc                                                                                                                                                                                              | Certification: | 4 Homicide determine                                                  |                                                                                                                                               | and at h         | ome                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | •            | Frederic                                | k MD            | IN LIEUTR    | et stree                         | t.          |
| Division To the Hospital or Attentivitin 24 hours after death To the Funeral Director:                                                                                                                                                 |                | 29a. Certifier 1 Certifying Phys                                      | sician: To the best of                                                                                                                        | my knowled       | ge, death occ                  | curred at the tir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ne, date and     | place, and   | d due to the ca                         | use(s) and ma   | anner as st  | ated.                            |             |
| To the Hos<br>within 24 h<br>To the Fur<br>completely                                                                                                                                                                                  | Medical        | one) 2 Medical Exami                                                  | ner:On the basis of e<br>and manner state                                                                                                     | xamination a     | nd/or investig                 | gation, in my of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | pinion, death    | occurred     | at the time, da                         |                 |              |                                  |             |
| E 3 E 8                                                                                                                                                                                                                                | Re             | 29b. Signature and title of certifier                                 |                                                                                                                                               |                  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | icense num       | ber          |                                         |                 |              | Month, Day, Yea                  | ar)         |
|                                                                                                                                                                                                                                        |                | Donna My                                                              | Imachti, a                                                                                                                                    | ND.              |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | D.C.M.E.         |              |                                         | Februa          | ry 27, 2     | 008                              |             |
| ~                                                                                                                                                                                                                                      |                | 30. Name and address of person w                                      | ho completed cause of                                                                                                                         | of death (Item   | 23a)                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |              |                                         |                 |              |                                  |             |
| 0                                                                                                                                                                                                                                      |                | Donna M. Vincenti, MD                                                 | Assistant Me                                                                                                                                  | _                |                                | 11 Penn St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | reet, Balt       | imore, N     | MD 21201                                |                 |              |                                  |             |
|                                                                                                                                                                                                                                        | tate           |                                                                       | 7010   WW.a                                                                                                                                   | trar's Signatu   | ire                            | well                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |              |                                         |                 |              |                                  |             |
| Regis                                                                                                                                                                                                                                  |                | Land Market 7 4 .                                                     | 2000                                                                                                                                          | THE MA           | - 6000                         | O-CONTRACTOR OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF |                  |              |                                         |                 |              |                                  |             |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITM/18, perFH 0878, 4/21/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 10:14 A.M Donoh FLAVURYY 24 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1504 Summit Avenue Catonsville <u>Baltimore</u> 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F Hours Yrs Director March 25,1918 Maryland 218-10-0333 89 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone. 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2 XNo Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1504 Summit Avenue USA 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No \$ Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 1942-45 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Sales Manager</u> Calculator Company 18. Mother's Name *(First, Middle, Maiden Surname)* **Magdalene**Mary <del>Magdalin</del> Wedekind 17. Father's Name (First, Middle, Last) Be James Patrick Donohue 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Miller Daughter 612 Woodsdale Road; Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 2/29/2008 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses 1901490 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute my Ocaval

Due to (or as a conservence of): Acute /Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sun to (or as a nonsequence of) Examiner The law requires that the death certificate be executed siclan and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physiclan for use as the burla Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performe certificate 25. Was case referred to medical examiner? MI Hospital or Attending Physician: director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this Certification: 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation the Funeral Director: Af 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) . Registrar's Signature State FEB 9 Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

20

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician FEBRUARY Day John Henry Dunkes Sr. 2008 4:47 AM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Examiner 4b. City, Town, or Location of Death Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Months Days Hours Director 220 22 5482 78 February 24 1930 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. inside City Limits 28a-f show ns 23a or 28a-f sho must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Belhaven Drive Items 23a 21236 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian Health and Mental Hygiene. tem 27 is marked other than "natural", or Item other traumatic event, the Medical Examiner. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced White WII 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)
NA Service Technician BG & E 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Dunkes Anna Hohman ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria M. Dunkes (Wife) 13 Belhaven Drive Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o
once. 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery February 29 2008 4 Donation 5 Dother (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the most shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician ADULT RESPIRATORY DISTRESS SYNDROME disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONEMIA Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the ending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant been signed by the atten should be detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ ACUTE RENAL FAILURE 1 ☐ Yes 2X No 3 ☐ Probabiy 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 K No 1 Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☒ No Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Piace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 08 37254 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 77601 OSL BOON P. LIM. M. D TOWSON. MARYLAND 21204 EB 2 9 2008 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5:10 AM. 2008 Emilie Elizabeth Espegren 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Washington Med Ctr Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/27/1919 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Hours Min 1 □ M 2 1 058-12-9950 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Ordnance Road, Apt., 404 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmaceutical Buyer Pharmaceutical Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Miller Maud Schantz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Espegren / 8467 Garden Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 ■ Burial 2 DCremation 3 □ Removal from State 20c. Location - City or Town, State 02/25/08 4 ☐ Donation \_5 ☐ Other (Specify) Baltimore, Cedar Hill Cem 21. Signature of Juneral Service Licensee 22. Name and Address of Facility G. J. Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, of c. in plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) renmonn Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760.

**Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran attending pl for use as t after death

I Director: within 24 hours aft

To the Funeral Di

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**Physician** 

/Medical

Examiner

Director

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Certification:

Medical

31. Date filed (Month, Day, Year)

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**Funeral** 

Director

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r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

and Mental Hygiene.

Is marked other than

Department of Health a important: If item 27 Is any injury or other trau

MMLIEEVED ES  $\Gamma E E$  Iltimore, Maryland 21215-0036

Baltimore,

Pages

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and add ss of person who completed cause of death (Iten

301

State Registrar

State of Maryland / Department of Health and Mental Hygiene 🗸 🗓 🖯 🖰 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 1 200 8 Month **Physician** TEDILIATY 21 000 Y 4c. County of Death FULWOOD 1823 James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saltmore Hopkins HUSPITA If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 2 F 219-50-0847 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at Baltimore 1 ☐YES 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2919 Erdman Avenue alal Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Specify: Black δ 3 Widowed 4 Divorced "natural", Completed 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pastor heligion 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be Moore Emma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erdman Ave Baltmore MD 21213

Ition (Name of Date 20c. Location - City or Town, State Mary Fulumd
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Daurial 2 □ Cremation 3 □ Removal from State 1/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MI 21. Signature of Funeral Service Licensee Voughn C. Greene Funeral Services Vaughn C. Steene 4905 York Rd Bultimore, Mi 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York And Baltimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY disease or condition resulting in death) /Medical Due to ( as a consequence of): Examiner Bilatere 5 SEVERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed Non-Small that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XNo 2 ER/Outpatient 3 DOA 1. Inpatient 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Tam 33. MEDICAL DOCTOR RES-000 Tebrutury 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Monica Busso Johns Hopkins Hospital, 600 N. Wolfe St. Baltimore MD 2126-31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 2. Date of Death 3. Time of Death Day **Physician** Month HLALG 900 AM HARLES 2008 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BATTIMONE MOSPITAL ERLY N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Days | Hours | Min. | June 14 1923 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1⊠M 2□F Months 218-16-1748 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🛛 No Anne Arundel Pasadena Directo Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1913 North Avenue 21122 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. MYes 2 No f Yes, Give ∕ear or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Coast Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Flaig Louis Theresa Hartman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Flaig (spouse) 1913 North Avenue, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Feb. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 2008 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 10 10 Medical Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

the burial-trar attending pi page 2 s director, this within 24 hours after death

To the Funeral Director:
completely filled in by the f

**Funeral** 

Director

r 28a-f show notified at

ms 23a or 7

permit. Pages 1 and 2 should be filed within 72 hours after deal obpartment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mun injury or other traumatic event, the Medical Examiner mun

**Physician** 

Pages 1 and 2 should be filed within 72 hours after in the feelth and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite

Baltimore, Maryland 21215-0036

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State Registrar

29b. Signature and title of certifier

6 Could not be determined

1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

BATTROPE, MD 21202

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL PLAZE 301

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

3 Suicide

4 Homicide

(Check only one)

**Physician** /Medical Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Examiner Exami after death.

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Director

by Funeral

Be Completed

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KNOWN TO PHYSIEIAN; FELTER,

NAME

Baltimore, Maryland 21215-0036

Completed by Physician/Medical 23b. Was decedent pregnant in the past 12 months? 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No P 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

HEALTH CARESYSTEM, PERRY POINT, MO 21902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Rigistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 06247 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Year 6:41 PM MICHAEL - FAY 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 104 Jackpine Drive Anne Arundel Pasadena If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07/03/1941 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2□ F ID 537-38**-**3669 66 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Pasadena MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21122 104 Jackpine Drive 12. Was Decedent Ever in U.S. Armed Forces? 1960 - 1976s 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 █ No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Service <u>Postal Carrier</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Fay Claudia Ashby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Jackpine Drive, Pasadena, MD 21122 Kathleen Fay / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bavview Crematory 102/25/08 | Baltimore, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility G. J. Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Parti. Enter the dire se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fa u.e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GLIOBLASTOHA MULTIFORYE 16 HONTITS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician /Medical **Examiner** The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, attending pl

**Physician** 

Examiner

**Funeral** 

Director

notified at

28a-f

7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a

and Mental Hygiene.

Is marked other than

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau
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**Funeral Director** 

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Be Completed

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Examine

Physician/Medical

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Be Completed

Certification: To

Medical

death with the Maryland

Baltimore, Maryland 21215-0036

2/14/08

/Medical

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

To the

State

29a. Certifier

29b. Signature and title of certifier Beicous

29c. License number

36033

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERCOVITZ

JOHNS HOPKINS

1135 ANNAPOUS ROAD OBENION FD

31. Date filed (Month, Day, Year) Registrar





State of Maryland / Department of Health and Mental Hygiene 008

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|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------------------------------------|-----------------------------------------------------|--------------------------------------|------------------------------|----------------------------------------------|------------------------------------------------------|
|                     | Physici                                                                                                                                                                                                                                | an             | 1. Decedent's Name (First, Middle, Last)                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                                                           |                                                     | 2. Date of De<br>Month               | Day                          | Year                                         | 3. Time of Death                                     |
|                     | /Medic<br>Examin                                                                                                                                                                                                                       | cal            | Gloria G. Falker  4a. Facility Name (If not institution, give the Riverview Care Cere)                                                                     | street and number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                | 4b. City, Town, o                                         | r Location of Death                                 | Februa                               |                              | , 2008<br>Inty of Death<br>Limore            | 10:20 A <sup>M</sup>                                 |
|                     | Funeral<br>Director                                                                                                                                                                                                                    |                | 5. Social Security Number 6. Security 100 100 100 100 100 100 100 100 100 10                                                                               | 7. Age (In yrs. In State 1)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ast birthday)<br>Yrs.          | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.                      | 8. Date of Bi<br>(Month, Di<br>11/21 | ay, Year)                    |                                              | olace (State or Foreigr<br>otry)<br>Land             |
|                     | and w                                                                                                                                                                                                                                  |                | Usual Residence of Decedent  10a. State 10b. County                                                                                                        | 10c. City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | , Town or Lo                   | ocation                                                   |                                                     |                                      |                              |                                              | 0d. Inside City Limits                               |
|                     | Maryl<br>-f sho                                                                                                                                                                                                                        | tor            | Maryland Baltimore                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                                                           |                                                     |                                      |                              |                                              | 1 ☐ Yes <b>2</b> ☐(No                                |
|                     | th with the<br>23a or 28a<br>ast be noti                                                                                                                                                                                               | ai Director    | 10e. Street and Number 52 South Hawthorne                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                | 10f. Zip Code<br>21220                                    |                                                     |                                      | 10g. Citizen U.S.A.          | of What Coun                                 | itry?                                                |
| 980                 | s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Item 27 is marked other than "neturet, or Items 23a or 28a-f show other traumetic event. The Medical Examination the notified at | by Funeral     | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced                                                                                         | 12. Was Decedent Ever in U.:<br>Armed Forces?<br>1 ☐ Yes 2/OXNo<br>If Yes, Give<br>Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1                              | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 🏋 No | lispanic Origin? (Span, Mexican, Puerto<br>Specity: | ecify Yes or No<br>Rican, etc.)      | 8                            | Race - Americ<br>Black, White,<br>ecify: Whi | etc.                                                 |
| Maryland 21215-0036 | l within 72 ho<br>jene.<br>r than "netui<br>Ine Medical                                                                                                                                                                                | Completed      | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0-12)                                                                           | cation<br>e completed)<br>College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (Give                          | DO NOT use retire                                         | during most of work                                 | sing                                 | 16b. Kind o                  | f Business/Ind                               | dustry                                               |
| land?               | 2 should be filed withir<br>and Mental Hygiene.<br>Is marked other than<br>sumetic event, the My                                                                                                                                       | To Be C        | 17. Father's Name (First, Middle, Last) Arthur P. Gray                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                | 11 12                                                     | 18. Mother's Nam<br>Louise                          |                                      | e, Maiden Sun                | name)                                        |                                                      |
| <b>dar</b>          | 12 sho                                                                                                                                                                                                                                 | ľ              | 19a. Informant's Name/Relationship (Ty                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                                                           | and Number or Rui                                   |                                      |                              |                                              | Code)<br>land 21220                                  |
|                     | iges 1 and 2<br>it of Health<br>if item 27<br>or other tre                                                                                                                                                                             |                | Casper J. Falkenha  20a. Method of Disposition  1  Burial                                                                                                  | 20b. Pl<br>emoval from State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | lace of Dispo<br>emetery, crei | esition (Name of<br>matory or other place                 | <sup>CB)</sup> 2/29                                 | Date 9/2008                          | 20c. Location                | on - City or To                              | own, State                                           |
| Baltimore,          | permit. Pages 1 a Department of Hes Importent: If item eny injury or othe                                                                                                                                                              |                | * 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 22                             |                                                           | 7 In¢<br>ss of Facility Bri<br>Lastern A            | uzdzins                              | ki Fun                       | eral Ho                                      |                                                      |
|                     | Physician<br>/Medical                                                                                                                                                                                                                  |                | 23a. Pari 1. Enter the disease, or simple high, or heard failure. List only or limm to the Cause (Final disease or condition resulting in death)           | cations the caused the death le cause each line.  L C C Due to (or as a consequence)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Do not ent                     |                                                           |                                                     |                                      |                              |                                              | Approximate Interval Between Onset and Death M. Chim |
| 0,                  | strifticate be executed by the physician and e as the burial-transit                                                                                                                                                                   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of t |                                |                                                           |                                                     |                                      |                              |                                              |                                                      |
| 68760,              | ate be<br>hysicia<br>the bu                                                                                                                                                                                                            | Medicai        | L.                                                                                                                                                         | d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                |                                                           |                                                     |                                      |                              |                                              |                                                      |
| .O. Box 68          | ath ce                                                                                                                                                                                                                                 | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                                                    | 3c. If yes, outcome of pregna. 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | death 3[                       | Ectopic pregnancy                                         | 1                                                   |                                      | 23d.                         | Date of delive<br>Month                      | ery<br>Day Year                                      |
| <u>α</u>            | uires that the de<br>signed by the a<br>Id be detached t                                                                                                                                                                               |                | Part II. Other significant conditions con                                                                                                                  | ntributing to death but not result                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | alting in the u                | 0                                                         | ren in Part I.                                      |                                      | tobacco use d                |                                              | ne cause of death?                                   |
| of Vital Records,   | The law require<br>ate has been sip<br>page 2 should b                                                                                                                                                                                 | Completed by   | DM·,                                                                                                                                                       | Asport                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ian                            | Pren                                                      | aig.                                                |                                      | ormed?                       | prior to cor<br>death?                       | psy findings available mpletion of cause of          |
| ital                |                                                                                                                                                                                                                                        | Be C           | 25. Was case referred to medical examiner?                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                |                                                           | 26. Place of Deal                                   | 1 ☐ Yes                              | 2 No                         | 1 🗌 Yes                                      | 2000                                                 |
| of V                | Physicien:<br>this certificatal director, I                                                                                                                                                                                            | 2              | 1 Yes 2 No                                                                                                                                                 | 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                | IL 3 DUA                                                  | er: 4 Nursing Ho                                    |                                      |                              |                                              | r)                                                   |
| Division o          | Attending F<br>death.<br>ctor: After<br>y the funera                                                                                                                                                                                   | Certification: | 27. Manner of Death  Matural 5 Pending  2 Accident investigation                                                                                           | 28a. Date of Injury<br>(Month, Day Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 28b. Time o<br>Injury          | Wor                                                       | yat<br>k?<br>Yes 2 □ No                             | 28d. Describe                        | how injury oc                | curred                                       |                                                      |
| Divi                | tel or Attences after deathers all Directors ed in by the sections.                                                                                                                                                                    | Certifi        | 3 Suicide 6 Could not be determined                                                                                                                        | 28e. Place of Injury - At ho building, etc. (Specify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | me, farm, str                  | eet, factory, office                                      |                                                     |                                      | (Street and Nu<br>wn, State) | umber or Rura                                | d Route Number,                                      |
|                     | To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune                                                                                                              | Medical        | 29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination                                                                                 | sician: To the best of my knowner: On the basis of examinat and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | wledge, deat<br>ion and/or in  | h occurred at the tir<br>vestigation, in my c             | me, date and place,<br>pinion, death occur          | and due to the<br>red at the time    | cause(s) and<br>date and pla | manner as si<br>ce, and due to               | tated. the cause(s)                                  |
| )                   | To the vithin 2 To the complete                                                                                                                                                                                                        | Σ              | 29b. Signature and title of certifier  M-D                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                | 29c. Licens                                               | 38-75                                               | .4                                   | 29d. Date sig                | gned (Month,<br>- 2-8 -                      | Day, Year)<br>2008                                   |
| 5                   | V                                                                                                                                                                                                                                      |                | 30. Name and address of person who co                                                                                                                      | mpleted cause of death (Item<br>ASBL M ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 23a) (Type,<br>709.            | Print) PAST                                               | 38-75<br>ERN                                        | BLUI                                 | ) . I                        | ND-                                          | 21221                                                |
|                     | Sta                                                                                                                                                                                                                                    | ite            | 31. Date filed (Month, Day, Year)                                                                                                                          | 32. Registrar's Signat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ture                           |                                                           |                                                     |                                      |                              |                                              |                                                      |

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------|------------------|------------------|------------------------------|---------------|----------------------------------------------------|--------------------|-------------------------|------------|--------------------------|---------------------------------------------------|----------------------------|--|
| David L. Fitzpatri                                                                                                                                                                                                                                                                                                    | ck,                    | Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | St                          | ate of I     | Maryland         |                  |                              |               |                                                    | Mental             | Hygien                  | е          |                          | 200                                               | 8 0624                     |  |
|                                                                                                                                                                                                                                                                                                                       |                        | 1- For State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                             |              |                  | Cert             | ificate o                    | of Death      | 7                                                  |                    |                         | Reg        | g. No.                   |                                                   |                            |  |
| Physicia                                                                                                                                                                                                                                                                                                              | _                      | Registrar  1. Decedent's Name (First, Middle,Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |              |                  |                  |                              |               |                                                    |                    | of Death                |            | Year                     | 3. Time of Death                                  |                            |  |
| Medical Examir                                                                                                                                                                                                                                                                                                        | ner                    | David                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Lee                         | Fitzp        | atrick           | Jr               |                              |               |                                                    |                    | Feb                     | ruary 2    | Day<br>3, 2008           |                                                   | 1343 hrs                   |  |
| ( "                                                                                                                                                                                                                                                                                                                   |                        | 4a. Facility Name (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | if not institution          | n, give stre | et and numbe     | er)              |                              |               |                                                    | ocation of De      | eath                    |            | 4c. Cou                  |                                                   |                            |  |
|                                                                                                                                                                                                                                                                                                                       |                        | 625 South [                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Ourham St                   | reet         |                  |                  |                              | Baltim        | ore                                                |                    |                         |            | Baltimore City           |                                                   |                            |  |
| Funeral                                                                                                                                                                                                                                                                                                               |                        | 5. Social Security N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | lumber                      | 6. Sex       |                  | Age (In yrs. las | st birthday)                 |               |                                                    |                    |                         |            |                          | Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign |                            |  |
| Director                                                                                                                                                                                                                                                                                                              |                        | 215 29 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 863                         | 1 X M        | 2 F              | 22               | Yı                           | Month:        | Days                                               | Hours              | Min. Deca               | ember      | 12 198                   | 35  : .c                                          | ountry) Maryland           |  |
|                                                                                                                                                                                                                                                                                                                       | Funeral Director       | Usual Residence o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | f Decedent                  |              |                  |                  |                              |               |                                                    |                    |                         |            |                          |                                                   |                            |  |
| any                                                                                                                                                                                                                                                                                                                   |                        | 10a. State 10b. County 10c. City, Town or Location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |              |                  |                  |                              |               |                                                    |                    | 10d. Inside City Limits |            |                          |                                                   |                            |  |
| nd<br>Show                                                                                                                                                                                                                                                                                                            |                        | Maryland Baltimore Parkville                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                             |              |                  |                  |                              |               |                                                    |                    | 1 Yes 2 No              |            |                          |                                                   |                            |  |
| aryla<br>8a-f                                                                                                                                                                                                                                                                                                         |                        | 10e. Street and Nu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Too. Direct diffa Hellings. |              |                  |                  |                              |               |                                                    | 10f. Zip Code      |                         |            |                          |                                                   | untry?                     |  |
| vith the Maryland<br>23a or 28a-f show s<br>200ified at once.                                                                                                                                                                                                                                                         |                        | 3022 Summit Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |              |                  |                  |                              |               | 21234                                              |                    |                         |            |                          | 4                                                 |                            |  |
| with t                                                                                                                                                                                                                                                                                                                |                        | 11. Marital Status 12. Was Decedent Ever in U.S. 13. W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |              |                  |                  |                              |               | as Decedent of Hispanic Origin? (Specify Yes or No |                    |                         |            |                          | Race - Ame<br>White, etc.                         | rican Indian, Black,       |  |
| eath item                                                                                                                                                                                                                                                                                                             |                        | 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |              |                  |                  |                              |               | ierto Rican,                                       | etc.)              |                         |            |                          |                                                   |                            |  |
| fer d                                                                                                                                                                                                                                                                                                                 |                        | 3 Widowed 4 Divorced If Yes, Give Year 2005–2006 1 Yes 2 X No specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |              |                  |                  |                              |               |                                                    |                    | Specify: White          |            |                          |                                                   |                            |  |
| urs af<br>tural                                                                                                                                                                                                                                                                                                       |                        | 15. Decedent's E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                             |              |                  |                  | 16a. Decede                  | ent's Usual   | Occupation                                         | on (Give kind      | d of work do            | ne         | 16b. Kind                | of Business                                       | s/Industry                 |  |
| 72 ho                                                                                                                                                                                                                                                                                                                 |                        | Elementary/Sec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ondary (0-12)               |              | College (1-4 o   | or 5+)           | auring                       | most of wor   | rking lile. I                                      | DO NOT use         | e reureu)               |            |                          |                                                   |                            |  |
| 5-0036<br>He within 72<br>Hygiene<br>J other than                                                                                                                                                                                                                                                                     |                        | 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |              | N⁄Α              |                  | Electr                       | ician         |                                                    |                    |                         |            | Elect                    | rician'                                           | s Union                    |  |
| 5-06<br>ed wi<br>tygien<br>other                                                                                                                                                                                                                                                                                      |                        | 17. Father's Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (First, Middle              | e, Last)     |                  |                  |                              |               | 1                                                  | 8.Mother's N       | Name (First,            | Middle, N  | Maiden Suri              | name)                                             |                            |  |
| 215<br>oe fillo<br>ntal H<br>ked                                                                                                                                                                                                                                                                                      | Be                     | David Lee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Fitzpat                     | rick S       | r                |                  |                              |               |                                                    | Veronio            |                         |            |                          |                                                   |                            |  |
| 2121<br>ould be fi<br>I Mental I<br>marked                                                                                                                                                                                                                                                                            | To Be Completed by I   | 19a. Informant's N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |              |                  |                  |                              |               |                                                    |                    |                         |            |                          |                                                   | te, Zip Code)              |  |
| MD<br>d 2 sho<br>lth and<br>n 27 is<br>aumati                                                                                                                                                                                                                                                                         |                        | Veronica V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Vendetti                    | . (Moth      | er)              |                  |                              |               |                                                    | Drive              |                         |            |                          |                                                   |                            |  |
| e, Land Healt Healt ritem                                                                                                                                                                                                                                                                                             |                        | 20a. Method of Dis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |              |                  |                  | Place of Disp<br>rematory or | osition (Na   | me of cem                                          | netery,            | Date                    |            | 20c. Loca                | ation - City                                      | or Town, State             |  |
| Baltimore, MD 21215-0036  bernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |              | Removal from     |                  | tro Cre                      |               |                                                    | ebruar             | v 25 20                 | 08         | Balt                     | imore.N                                           | Yaryland                   |  |
| Iting it. Partiment your                                                                                                                                                                                                                                                                                              |                        | 4 Donation 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Other S                     |              |                  |                  | 22                           | . Name and    | Address                                            | of Facility        |                         |            |                          |                                                   |                            |  |
| Ba<br>Perm<br>Depa<br>Impe                                                                                                                                                                                                                                                                                            |                        | Lassahn Funeral Home Inc  7/01 Belair Road Baltimore Maryland 21236  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Retween Onset and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |              |                  |                  |                              |               |                                                    |                    |                         |            |                          |                                                   |                            |  |
| Physician                                                                                                                                                                                                                                                                                                             |                        | 23a, Part I. Enter t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | he disease, c               | or complicat | tions that caus  | ed the death.    | Do not ente                  | r the mode    | of dying,                                          | such as card       | liac or respi           | ratory arr | est, shock,              | or heart                                          | Approximate Interval       |  |
| /Medical                                                                                                                                                                                                                                                                                                              | er                     | failure. List o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | nly one cause               | e on each l  | ine.             |                  |                              |               |                                                    |                    |                         |            |                          |                                                   | Between Onset and<br>Death |  |
| <b>xaminer</b>                                                                                                                                                                                                                                                                                                        |                        | Immediate Cause (Final disease a. Hanging a. Hanging Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                             |              |                  |                  |                              |               |                                                    |                    |                         |            |                          |                                                   |                            |  |
|                                                                                                                                                                                                                                                                                                                       |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             | h            | . 10 (01 05 0 00 | ooquooo o.       | ,                            |               |                                                    |                    |                         |            |                          |                                                   |                            |  |
|                                                                                                                                                                                                                                                                                                                       |                        | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             |              |                  |                  |                              |               |                                                    |                    |                         |            |                          |                                                   |                            |  |
|                                                                                                                                                                                                                                                                                                                       | Examine                | cause. Enter Underlying Cause                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                             |              |                  |                  |                              |               |                                                    |                    |                         |            |                          |                                                   |                            |  |
| V 9 5                                                                                                                                                                                                                                                                                                                 | Xal                    | events resulting in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             | Due          | to (or as a co   | nsequence of     | i):                          |               |                                                    |                    |                         |            |                          |                                                   |                            |  |
| A and and trans                                                                                                                                                                                                                                                                                                       | calE                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             | d            |                  |                  |                              |               |                                                    |                    |                         |            |                          |                                                   |                            |  |
| oe ex<br>ician                                                                                                                                                                                                                                                                                                        | ģ                      | UNPENDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 0                           | _ A          | MENDED           |                  |                              |               |                                                    |                    |                         |            |                          |                                                   |                            |  |
| Box 68760, a death certificate be the attending physic ed for use as the bur                                                                                                                                                                                                                                          | /Me                    | IF FEMALE:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | t pregnant in               |              | 23c. If yes, out |                  |                              |               | 2                                                  | Estanian           |                         |            |                          | ate of deliv                                      | ery<br>Day Year            |  |
| 68<br>certifi                                                                                                                                                                                                                                                                                                         | ian                    | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 5 Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             |              |                  |                  |                              |               | Day                                                |                    |                         |            |                          |                                                   |                            |  |
| eath c                                                                                                                                                                                                                                                                                                                | Physician/Medi         | 1 Yes 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | No 9 U                      | nknown       | Unknow           |                  | 5                            | Other (Sp     | ecity)                                             |                    |                         |            |                          |                                                   |                            |  |
|                                                                                                                                                                                                                                                                                                                       |                        | Part II. Other sign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | nificant cond               |              |                  |                  | esulting in th               | e underlyin   | g cause g                                          | iven in Part       | l. 2                    | 23e. Did t | obacco use               | contribute                                        | to the cause of death?     |  |
| P.O.                                                                                                                                                                                                                                                                                                                  | þ                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |              | Ü                |                  |                              |               |                                                    |                    | - 1                     | 1Ye        | s 2 🗸 N                  | lo 3 P                                            | robably 4 Unknown          |  |
| S,                                                                                                                                                                                                                                                                                                                    | ted                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |              |                  |                  |                              |               |                                                    |                    | — t                     | 24a. Was   | an I                     | 24b. Were                                         | autopsy findings available |  |
| ord<br>w recast be                                                                                                                                                                                                                                                                                                    | Completed              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |              |                  |                  |                              |               |                                                    |                    | — I                     | auto       | psy<br>ormed?            | prior 1<br>death                                  | to completion of cause of  |  |
| The la                                                                                                                                                                                                                                                                                                                | E                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |              |                  |                  |                              |               |                                                    |                    | 1                       |            | 2 🗸 No                   | 1                                                 | Yes 2 No                   |  |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach                                                                                                    | Be C                   | 25. Was case refe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | erred to medic              | cal          |                  |                  |                              |               | 26.Place                                           | of Death (C        | heck only o             |            |                          | -                                                 |                            |  |
| ion of Vital rending Physician: eath. for: After this certifute funeral director,                                                                                                                                                                                                                                     | 0 0                    | examiner?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2 No                        | Hos          | pital: 1 Inp     | atient 2         | ER/Outpati                   | ent 3         | DOA                                                | Other <sub>4</sub> | Nursing Hor             | ne 5       | Residenc                 | e 6 🗸 Ot                                          | her: Scene                 |  |
| n of Vit<br>ding Physic<br>n. After this                                                                                                                                                                                                                                                                              | -                      | 27. Manner of De                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                             |              | 28a. Date of     | Injury           | 28b. Time                    | of Injury     | 28c. Inju                                          | ry at Work?        |                         |            | how injury               |                                                   |                            |  |
| on<br>endin<br>ath.<br>rr: A                                                                                                                                                                                                                                                                                          | Medical Certification: | 1 Natural 5 Pending FOUND: 1 Yes 2 No Subject hanged s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |              |                  |                  |                              |               |                                                    | ilged ooi          |                         |            |                          |                                                   |                            |  |
| isic<br>Atte<br>er dea<br>recto                                                                                                                                                                                                                                                                                       |                        | 2 Accident Investigation   Accident   Accide |                             |              |                  |                  |                              |               |                                                    |                    |                         |            | Rural Route Number, City |                                                   |                            |  |
| Div<br>tal or<br>al Div                                                                                                                                                                                                                                                                                               |                        | 3 V Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse or Town, State) 625 South Durham Street, Baltimore, MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             |              |                  |                  |                              |               |                                                    |                    |                         |            |                          | more, MD                                          |                            |  |
| Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the                                                                                                                                                                                                  |                        | 29a. Certifier and place and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |              |                  |                  |                              |               |                                                    |                    |                         |            |                          |                                                   |                            |  |
| the H<br>in 24<br>the F<br>iplete                                                                                                                                                                                                                                                                                     |                        | (Check only one) 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Medical Ex                  | kaminer: O   | n the basis of   | examination a    | ind/or invest                | igation, in r | ny opinion                                         | , death occu       | urred at the            | time, date | e and place              | , and due to                                      | o the cause(s)             |  |
| To the within To the comple                                                                                                                                                                                                                                                                                           |                        | and manner stated.  29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             |              |                  |                  |                              |               | 29c. License number                                |                    |                         |            |                          | 29d. Date signed (Month, Day, Year)               |                            |  |
|                                                                                                                                                                                                                                                                                                                       |                        | 0 11/1/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             |              |                  |                  |                              | O.C.M.E.      |                                                    |                    |                         |            | Febru                    | February 24, 2008                                 |                            |  |
|                                                                                                                                                                                                                                                                                                                       |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4/                          | VVI          | 10               | -64- 0.00        | 005                          |               |                                                    |                    |                         |            |                          |                                                   |                            |  |
| (1)                                                                                                                                                                                                                                                                                                                   | NI S                   | 30. Name and ad                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |              | npleted cause    |                  | _                            | Penn Str      | eet Ral                                            | timore, M          | 1D 21201                |            |                          |                                                   |                            |  |
| 2731                                                                                                                                                                                                                                                                                                                  |                        | Jack Titus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ועוט. טו                    | eputy Cr     | nief Medica      | LAMITINE         |                              |               | JUL, Dal                                           |                    | 0 1                     |            |                          |                                                   |                            |  |

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State 31. Date filed (Mar Ballyell) 2008

United States Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Specify. White 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Surname) Alberta Dow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9906 Wildwood Road, Kensington, Maryland 20895 20c. Location - City or Town, State Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda-Chevy Chase, Inc. 75 Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2137No 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 2126108 00057124 **ORIGINAL** 

Registrar

State

1. Decedent's Name (First, Middle, Last)

**Physician** 

/Medical

Examiner

**Funeral** 

Certificate of Death

Charlotte G. Fletcher

4b. City, Town, or Location of Death

2. Date of Death February 25, 2008

3. Time of Death 12:45PM M

4a. Facility Name (If not institution, give street and number)

Manor Care Potomac 5. Social Security Number

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Yrs.

Potomac Days Hours

8. Date of Birth (Month, Day, Year)

 Birthplace (State or Foreign Country) New York

Montgomery

Year

4c. County of Death

10d. Inside City Limits 1 ☐ Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, M.D. 9715 Medical Center Drive, #201 Rockville, Maryland 20850

31. Date filed (Month, Day, Year) 29 32. egistrar's Signature



|                                |                                                                                                                            |                                                | For<br>State<br>Registrar                                                                                                                                                                                                     | State of N                                                                                            | Marylan                                        |                                  | artment of<br><i>rtificate of</i>          |                                 |                                             | ental H                                                            | ygien<br>Reg. N             | 20                      | 08                        | 06251                                         |
|--------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------|--------------------------------------------|---------------------------------|---------------------------------------------|--------------------------------------------------------------------|-----------------------------|-------------------------|---------------------------|-----------------------------------------------|
| P                              | Dhysia                                                                                                                     |                                                | 1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death                                                                                                                                                  |                                                                                                       |                                                |                                  |                                            |                                 |                                             |                                                                    |                             |                         |                           | 3. Time of Death                              |
| 4                              | Physici<br>/Medi                                                                                                           |                                                | Rose Marie Fyo                                                                                                                                                                                                                | February                                                                                              |                                                |                                  |                                            |                                 | ry 26, 2008 12:41 P.M                       |                                                                    |                             |                         |                           |                                               |
|                                | Examir                                                                                                                     | PERSONAL PROPERTY.                             | 4a. Facility Name (If not instituti                                                                                                                                                                                           | 4b. City, Town,                                                                                       | of Death                                       | 4                                | 4c. County of Death                        |                                 |                                             |                                                                    |                             |                         |                           |                                               |
|                                | -3:                                                                                                                        |                                                | Shady Grove Ad                                                                                                                                                                                                                |                                                                                                       | Rockville                                      |                                  |                                            |                                 |                                             | Montgomery                                                         |                             |                         |                           |                                               |
| k                              | Funeral<br>Director                                                                                                        |                                                | 579-24-7946 1□ M 2戻F                                                                                                                                                                                                          |                                                                                                       |                                                | last birthday)<br>Yrs.           | If Under 1 Year<br>Months Days             |                                 |                                             | 8. Date of E<br>(Month, I<br>March 9                               |                             |                         | Cour                      | lace (State or Foreign<br>try)<br>Lngton, D.C |
|                                | and w                                                                                                                      |                                                | Usual Residence of Decedent  10a. State 10b. Count                                                                                                                                                                            | v                                                                                                     | 10c. Cit                                       | v. Town or Lo                    | cation                                     |                                 |                                             |                                                                    |                             |                         | 1                         | 0d. Inside City Limits                        |
|                                | Maryl<br>f sho                                                                                                             | ō                                              | Maryland Montg                                                                                                                                                                                                                | ,                                                                                                     |                                                | ville                            |                                            |                                 |                                             |                                                                    |                             |                         | '                         | 1 ⊠Yes 2 □ No                                 |
|                                | with the Maryland<br>a or 28a-f show<br>the notified at                                                                    | Director                                       | 10e. Street and Number                                                                                                                                                                                                        |                                                                                                       | 11001                                          |                                  | 10f. Zip Code                              |                                 |                                             |                                                                    | 10g C                       | itizen of \             | What Cour                 |                                               |
|                                | 3a or                                                                                                                      | I D                                            | 1609 Coral Sea                                                                                                                                                                                                                | Drive                                                                                                 |                                                |                                  | 20851                                      |                                 |                                             |                                                                    | State                       |                         |                           |                                               |
|                                | death<br>ms 2                                                                                                              | Funeral                                        | 11. Marital Status                                                                                                                                                                                                            | 12. Was Deceder                                                                                       | nt Ever in U                                   | .S. 13.                          | Was Decedent of<br>If Yes, specify Cul     | Hispanic Or                     | rigin? (Spec                                | cify Yes or N                                                      |                             |                         | e - Americ                |                                               |
| Baltimore, Maryland 21215-0036 | 72 hours after death with the Maryland<br>"natural", or Items 23a or 28a-f show<br>kdlcal Examiner must be notified at     | by Fu                                          | 1 ☐ Never Married 2 ☐ Ma<br>3 🔯 Widowed 4 ☐ Divorce                                                                                                                                                                           | If Yes Give                                                                                           | No.                                            |                                  | if Yes, specify Cul<br>1 ☐ Yes 2 🖾 No      |                                 |                                             | Rican, etc.)                                                       |                             | Blac<br>Specify         | ck, White,                | <sub>etc.</sub><br>hite                       |
| 9-0                            | 2 hou                                                                                                                      | To Be Completed                                | 15. Decede                                                                                                                                                                                                                    | nt's Education                                                                                        |                                                | 16a. Dece                        | dent's Usual Occu                          | pation                          |                                             |                                                                    | 16b.                        | Kind of B               | usiness/Inc               |                                               |
| 218                            | within 7<br>ene.<br>than "n<br>he Med                                                                                      |                                                | (Specify only high<br>Elementary/Secondary (0-12)                                                                                                                                                                             | est grade completed)  College (1-4o                                                                   | or 5+)                                         | (Give                            | kind of work done DO NOT use retire        | e during mo:<br>ed)             | st of workin                                | ng                                                                 |                             |                         |                           | ,                                             |
| 2                              | yd wil                                                                                                                     |                                                | 12                                                                                                                                                                                                                            |                                                                                                       | Billi                                          | ng Clerk                         |                                            | Printing                        |                                             |                                                                    |                             |                         |                           |                                               |
| nd                             | be filed within 72 h<br>ntal Hygiene.<br>id other than "natu<br>event, the Medical                                         |                                                | 17. Father's Name (First, Middle                                                                                                                                                                                              | ,                                                                                                     |                                                |                                  |                                            | 1                               |                                             | (First, Middi                                                      | le, Maide                   | en Surnan               | ne)                       |                                               |
| yla                            | 2 should be filed<br>and Mental Hygi<br>is marked other<br>aumatic event, <u>t</u>                                         |                                                | Frederick Will                                                                                                                                                                                                                |                                                                                                       |                                                |                                  |                                            |                                 | 7 S. M                                      |                                                                    |                             |                         |                           |                                               |
| Лаг                            | s 1 and 2 should<br>f Health and Mer<br>Item 27 is marke<br>other traumatic                                                |                                                | 19a. Informant's Name/Relation                                                                                                                                                                                                |                                                                                                       |                                                | 1                                | ng Address (Stree                          |                                 |                                             |                                                                    |                             |                         |                           |                                               |
| e)                             | and<br>lealth<br>m 27<br>her t                                                                                             |                                                | Robert L. Fyoc                                                                                                                                                                                                                | k / Son                                                                                               | 001                                            |                                  | Coral Se                                   |                                 |                                             |                                                                    | -                           |                         |                           |                                               |
| Ö                              | iges<br>or of                                                                                                              |                                                | 20a. Method of Disposition<br>1 ☑ Burial 2 ☐ Cremation                                                                                                                                                                        |                                                                                                       | te 206. F                                      | riace of Dispo<br>semetery, crei | sition (Name of<br>matory or other pla     | 1                               |                                             | ate                                                                |                             |                         | City or To                |                                               |
| ţ                              | t. Partmer                                                                                                                 |                                                | 4 □ Donation 5 □ Other (                                                                                                                                                                                                      |                                                                                                       | Parl                                           |                                  | morial Par                                 |                                 |                                             |                                                                    | 1                           |                         | -                         | aryland                                       |
| Bal                            | permit, Pages 1 and 2. Department of Health ar Important: If Item 27 is any Injury or other trau                           |                                                | 21. Signature of Funeral Service                                                                                                                                                                                              | X                                                                                                     | 100896                                         | RC 30                            | Dobert A.<br>00 W. Mor                     | ess of Facil<br>Pumph<br>itgome | irey E<br>ery Av                            | Tunera<br>7e., R                                                   | 1 Ho<br>ockv                | me/R                    | ockvi<br>, MD             | lle, Inc.<br>20850-2805                       |
|                                |                                                                                                                            |                                                | 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.  Approximate Interval |                                                                                                       |                                                |                                  |                                            |                                 |                                             |                                                                    |                             |                         |                           |                                               |
| М                              | Physician `                                                                                                                |                                                | Immediate Cause (Final disease or condition                                                                                                                                                                                   |                                                                                                       |                                                |                                  | ovascula                                   |                                 |                                             |                                                                    |                             |                         |                           | Onset and Death                               |
| 4                              | /Medical                                                                                                                   |                                                | resulting in death)                                                                                                                                                                                                           |                                                                                                       | as a conseq                                    |                                  | -                                          |                                 |                                             |                                                                    |                             |                         |                           |                                               |
| l.                             | Examiner                                                                                                                   |                                                | Sequentially list conditions.                                                                                                                                                                                                 | b                                                                                                     |                                                |                                  |                                            |                                 |                                             |                                                                    |                             |                         |                           |                                               |
| J                              | ed sit                                                                                                                     | ine                                            | Sequentially list conditions, if any, leading to immediate cause. Enter Uncarrying Cause (Disease or injury that initiated events                                                                                             | Due to (or a                                                                                          | or as a consequence of):                       |                                  |                                            |                                 |                                             |                                                                    |                             |                         |                           |                                               |
| ٧                              | icate be executed<br>physician and<br>s the burial-transit                                                                 | Examiner                                       | that initiated events<br>resulting in death) Last                                                                                                                                                                             | C                                                                                                     |                                                | a consequence of):               |                                            |                                 |                                             |                                                                    |                             |                         |                           |                                               |
| .09                            | be ey<br>ician<br>buria                                                                                                    |                                                |                                                                                                                                                                                                                               | Due to (or a                                                                                          | uence on.                                      |                                  |                                            |                                 |                                             |                                                                    |                             |                         |                           |                                               |
| 68760,                         | ificate be executed<br>g physician and<br>as the burial-transit                                                            | edical                                         |                                                                                                                                                                                                                               | d                                                                                                     |                                                |                                  |                                            |                                 |                                             |                                                                    |                             |                         |                           |                                               |
|                                | certific<br>iding p                                                                                                        | //Me                                           | IF FEMALE:                                                                                                                                                                                                                    | 23c. If yes, outcom                                                                                   | ne of pregna                                   | incv                             |                                            |                                 |                                             | ·                                                                  |                             |                         |                           |                                               |
| Вох                            | seath<br>atter<br>I for u                                                                                                  | ciar                                           | 23b. Was decedent pregnant in the past 12 months?                                                                                                                                                                             | 1 ☐Live birth<br>4 ☐ Pregnant                                                                         | 2 🗆 Feta                                       | Ideath 3□                        | Ectopic pregnand<br>Other <i>(specify)</i> | СУ                              |                                             |                                                                    |                             |                         | te of delive<br>inth      | ery<br>Day Year                               |
| 0                              | the c<br>y the<br>ached                                                                                                    | Be Completed by Physician/M                    | 1 ☐ Yes 2 🙀 No<br>9 ☐ Unknown                                                                                                                                                                                                 | 9□Unknown                                                                                             |                                                |                                  | 2 Other (opening)                          |                                 |                                             |                                                                    |                             |                         |                           |                                               |
| ٩,                             | requires that the death cer<br>sen signed by the attendin<br>rould be detached for use                                     |                                                | Part II. Other significant condit                                                                                                                                                                                             | nderlying cause gi                                                                                    | ven in Part                                    | l.                               | 23e. Did                                   | tobacco                         | bacco use contribute to the cause of death? |                                                                    |                             |                         |                           |                                               |
| Records,                       | w requires that the death cert<br>been signed by the attendin<br>should be detached for use :                              |                                                | Hypertension                                                                                                                                                                                                                  | 1                                                                                                     |                                                |                                  |                                            |                                 | _                                           | 1 [                                                                | ] Yes                       | 2□ No                   | 3 ☐ Prob                  | ably 4 ☑Unknown                               |
| 00                             | law re<br>as bee<br>2 shou                                                                                                 |                                                | High Cholest                                                                                                                                                                                                                  | ero1                                                                                                  |                                                | 24a. Wa                          | Vas an 24b. Were autopsy                   |                                 |                                             | nev findinge available                                             |                             |                         |                           |                                               |
| R                              | The la                                                                                                                     |                                                |                                                                                                                                                                                                                               |                                                                                                       |                                                |                                  |                                            |                                 |                                             | aut                                                                | opsy<br>formed?             |                         | prior to co:<br>death?    | npletion of cause of                          |
| Vital                          |                                                                                                                            |                                                | 25. Was case referred to medic                                                                                                                                                                                                | al                                                                                                    |                                                |                                  |                                            | 26 Place                        | e of Death                                  | 1 Yes                                                              |                             | lo                      | 1 □ Yes                   | 2□ No                                         |
| >                              | Physician:<br>this certific<br>at director,                                                                                | ToB                                            | examiner?<br>1 ☐ Yes 2 ☐ No                                                                                                                                                                                                   | 26. Place of Death (Check only one)  3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □Other (Specify) |                                                |                                  |                                            |                                 |                                             |                                                                    |                             |                         |                           |                                               |
| 1 Or                           |                                                                                                                            |                                                | 27. Manner of Death                                                                                                                                                                                                           | 1 ☐ Inpa                                                                                              | njury                                          | 28b. Time of                     |                                            |                                 |                                             | 8d. Describe                                                       | _                           |                         |                           | //                                            |
| 0                              | dutenain<br>death.<br>ctor: Afi<br>y the fur                                                                               | Te 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No |                                                                                                                                                                                                                               |                                                                                                       |                                                |                                  |                                            |                                 |                                             |                                                                    |                             |                         |                           |                                               |
| Division                       | r Attending<br>er death.<br>rector: Afte<br>by the fune                                                                    | titic                                          | 3 Suicide 6 Could<br>4 Homicide determ                                                                                                                                                                                        | njury - At ho<br>etc. (Specif                                                                         | t home, farm, street, factory, office 28f. Loc |                                  |                                            |                                 |                                             | ation (Street and Number or Rural Route Number,<br>or Town, State) |                             |                         |                           |                                               |
|                                | Ital or rs after all Different bill bill bill bill bill bill bill bil                                                      | Çe                                             |                                                                                                                                                                                                                               |                                                                                                       |                                                |                                  |                                            |                                 |                                             | Ony or 11                                                          | JWII, Sta                   | <i>(e)</i>              |                           |                                               |
|                                | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu | Medical                                        | 29a. Certifier 15 Certify (Check only one) 2 Wedica                                                                                                                                                                           | ng Physician: To the bes<br>I Examiner: On the basis<br>and manner:                                   | of examina                                     | wledge, deatl<br>tion and/or in  | n occurred at the t<br>vestigation, in my  | ime, date a<br>opinion, de      | nd place, a<br>ath occurre                  | nd due to the                                                      | e cause(<br>e, date a       | s) and mand mand place, | anner as si<br>and due to | ated.<br>the cause(s)                         |
| _                              | To the within To the comp                                                                                                  | Me                                             | 29b. Signature ar d title or certifi                                                                                                                                                                                          | er                                                                                                    |                                                |                                  | <u></u>                                    | 29d. Dat                        |                                             |                                                                    | e signed (Month, Day, Year) |                         |                           |                                               |
|                                |                                                                                                                            |                                                | · MA ~                                                                                                                                                                                                                        |                                                                                                       |                                                |                                  | D0061415                                   |                                 |                                             |                                                                    |                             | 2 26 2008               |                           |                                               |
|                                | 12                                                                                                                         | İ                                              | 30. Name and address of person                                                                                                                                                                                                | who completed cause of                                                                                | death (Item                                    | 23a) (Type,                      | - 1                                        | •                               |                                             |                                                                    |                             | 1                       | 1                         |                                               |
| _                              | , ,                                                                                                                        |                                                | Manish K. Gamb                                                                                                                                                                                                                |                                                                                                       |                                                |                                  |                                            | #202,                           | Rock                                        | ville                                                              | , Ma                        | ry1a:                   | nd 20                     | 850                                           |
| т                              | Sta                                                                                                                        | te                                             | 31. Date filed (Month, Day, Year                                                                                                                                                                                              | 2.000                                                                                                 | strar's Signa                                  | ~~~                              |                                            |                                 |                                             | <u></u>                                                            |                             |                         |                           |                                               |

DHMH 17 Rev 1/2001

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** 6701 AM MAUL EEHELY FEBRUARY 27 2008 /Medical Town, or Location. BALTIMORE 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | MAY 5, 1950 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS HOPKINS BAPVIEW MEDICAL CENTER 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1**X** M 2□ F Director 218-64-4854 MARÝLAND Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes XXNo Director MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 2602 SONN LANE 21234 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify δ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) 0 DISABLED N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS G. FEEHELY ANNA Μ. THOMAS ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is other tra DONNA THOMAS/ SISTER VISTA RD., KINGSVILLE, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of h Important: If ite any injury or ot 1 XBurial 2 □ Cremation 3 □ Removal from State SACRED HEART OF JESUS 3/1/08 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PULMONARY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed and Due to (or as a consequence of) P.O. Box 68760 the attending physician The law requires that the death certificate be Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient ۴ 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of s after death. 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 ☐ Homicide determined within 24 hours a To the Funeral I Medical 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

the

State Registrar

MARISHA 31. Date filed (Month, Day, Year) 2008

ess of person who completed cause of death (Item 23a) (Type, Print)

4940

EASTERN AVENUE BALT, MORE, MD 21224 32 Pegistrar's Signature

29b. Signature and title of certifier

29c. License number

RES - 00

29d. Date signed (Month, Day, Year)

State Registrar

OCME 2006

DHMH 17 Rev 1/2001

Carol Allan, MD As

31. Date filed (Month, Day, Year)

FEB 2 9

1

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

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| Physician<br>/Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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                                                                                             | Registrar<br>Decedent's Name                                                                                                                                                                                                                                                                                                                                   | 4.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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Date of Death Month FUNTY     | Day<br>21     | Year<br>200 g                                |                                                          |
| Examiner Funeral Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ve street and fumber) Sex 7. Ag 1 □ M 2 ☑ F                             | e (In yrs. last bir.<br>88                | thday)<br>Yrs.              | 4b. City, Town, o                                            | Hya                             | ttsvi<br>er 24 Hrs. | 8. Date of Birth<br>(Month, Day, | Pri           | 9. Birth                                     | eorges  splace (State or Foreign untry)                  |
| Maryland I-f show fled at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | sual Residence of<br>0a. State                                                                                                                                                                                                                                                                                                                                 | Decedent<br>10b. County                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | e Georges                                                               | 10c. City, Town                           |                             |                                                              |                                 |                     |                                  |               |                                              | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No                   |
| fter death with the Mar<br>r items 23a or 28a-f sh<br>liner must be notified<br>liner must Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Oe. Street and Nur  2006 Woo  1. Marital Status                                                                                                                                                                                                                                                                                                                | mber                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 12. Was Decedent                                                        |                                           |                             | 10f. Zip Code<br>20783                                       |                                 | Origin? (Spe        |                                  |               | ed Sta                                       |                                                          |
| hours after d ural", or item al Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Armed Forces? 1 ⊠Yes 2 □ I If Yes, Give Year or Dates:                  | No<br>1943-46                             |                             | Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 ☑ No        | Speci                           |                     |                                  |               |                                              | ite                                                      |
| filed within 72 hours after death with the Maryland Hygiene. Hygiene, Hygiene, whither than "natural" or items 23a or 28a-f show ant, the Medical Examiner must be notified at e. Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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                                                                                                                                                                                                                                                                                                                         | rade completed) College (1-4or 5                                        | 5+)                                       | (Give                       | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | during m<br>d)                  |                     | ing                              | Medi          | cine                                         | naustry                                                  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene was the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map of the map |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7. Father's Name  Curtis  19a. Informant's Name                                                                                                                                                                                                                                                                                                                | Hammer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         | 19b                                       | . Maili                     | ing Address (Street                                          | В                               | essie               | Harman  Al Route Number          |               |                                              | ip Code)                                                 |
| Pages 1 and 2 timent of Health a tant: If Item 27 is jury or other trau                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0a. Method of Disp                                                                                                                                                                                                                                                                                                                                             | position Cremation 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | e/Husband  □Removal from State                                          | 20b. Place or cemete                      | f Dispo                     | osition (Name of ematory or other pla                        | ce)                             | ı                   | Feb 25                           | 20c. Locatio  | on - City or                                 | Town, State                                              |
| permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4 □ Donation  21. Signature of Fu                                                                                                                                                                                                                                                                                                                              | 5 □ Other (Specureral Service Lic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                         | Ches<br>00382<br>-                        |                             | eake Crema<br>2. Name and Addre<br>Rapp Fune<br>933 Gist     | ess of Fa                       | cility<br>& Cren    | ation Se                         | rvices        |                                              |                                                          |
| res that the death certificate be executed rest that the death certificate be executed with the attending physician and be detached for use as the burial-transit by Dhysician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23a. Part1. Enfer shock, or hes immediate Cause disease or condition resulting in death)  Sequentially list confirm, leading to include a fany, leading to include a fany, leading to include a fany, leading to include a fany, leading to include a fany, leading to include a fany, leading to include a fany, leading to include a fany, leading in death) | (Final on on of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the c | b                                                                       | a consequence a consequence a consequence | NACO<br>ON):                | iter the mode of dying the He<br>1 this / ste<br>ematic      | ng, such<br>MAT<br>MOSI<br>HEAY | as cardiac Failu    | or respiratory arm               | est,          |                                              | Approximate Interval Between Onset and Death Years Years |
| The law requires that the death certificate be the has been signed by the attending physicis age 2 should be detached for use as the but completed by Physician/Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | F FEMALE:<br>23b. Was deceder<br>in the past 12<br>1  Yes 2<br>9  Unknowr                                                                                                                                                                                                                                                                                      | months?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown | 2 Fetal death                             |                             | □Ectopic pregnand<br>□ Other <i>(specify)</i> _              | су                              |                     |                                  | 23d.          | Date of del<br>Month                         | ivery<br>Day Year                                        |
| w requires that been signed by should be deta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Part II. Other signi                                                                                                                                                                                                                                                                                                                                           | ificant conditions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | contributing to death b                                                 | out not resulting i                       | n the (                     | underlying cause gi                                          | ven in Pa                       | ırt I.              | 23e. Did to                      |               | /                                            | the cause of death?                                      |
| stcian: The law requii                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>S</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 25. Was case refe                                                                                                                                                                                                                                                                                                                                              | rred to medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                         |                                           |                             |                                                              | 26 PI                           | ace of Deat         | 24a. Was a autops perform 1 Yes  | med?<br>2 ANo | 4b. Were au<br>prior to<br>death?<br>1 ☐ Yes | utopsy findings available completion of cause of         |
| ; £ ± ± 5 F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | examiner? 1 Yes 2 2 27. Manner of Dea 1 Natural 2 Accident                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Hospital: 1 ☐ Inpati 28a. Date of Inj (Month, Da                        | ury 28b.                                  | utpatie<br>Time (<br>Injury | of 28c. Inju                                                 | her: 4 🗆                        | Nursing Ho          |                                  | ence 6 🗆      |                                              | cify)                                                    |
| oital or Attending F<br>urs after death.<br>eral Director: After<br>illed in by the funer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2   Accident   Acciden |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                         |                                           |                             |                                                              |                                 |                     |                                  |               |                                              |                                                          |
| To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Modical Certi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 200                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 29a. Certifier (Check only one) 29b. Signature and                                                                                                                                                                                                                                                                                                             | 2□ Medical Ex                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Physician: To the best<br>aminer: On the basis of<br>and manner s       | of examination a                          | e, dea                      | ath occurred at the finvestigation, in my                    | opinion,                        | death occu          | rred at the time, o              | date and pla  | gned (Mon                                    | e to the cause(s)<br>th, Day, Year)                      |
| 121                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 30. Name and and                                                                                                                                                                                                                                                                                                                                               | Iress of person wh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | no completed cause of                                                   | death (Item 23a)                          |                             |                                                              | Was                             | 50 f                | bourte,                          | MA            | Cilian                                       | 17 26 2005<br>apring 14291                               |
| State<br>Registra                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 31. Date filed (Mo                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 9 2008 32. Rec                                                          | rar's Signature                           | ۲ ,                         | front                                                        | WIT                             | say ()              | DIN HUP                          | jup.          | 11/1/1/                                      | ynny to feel                                             |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Feb 25<sup>Day</sup> Michael T. Gast 2008 1:44a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella MAris Hospice Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Min. | Nov. 1, 1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 219-40-9242 Yrs. 64 **Director** MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits MD Baltimore Rosedale 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 13 Barletta Court 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Eastern Glass <u>12th</u> Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Gast Anna Streckfus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Gast / wife 13 Barletta Court Baltimore MD 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State **½** Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 2/28/08 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that cause 10 e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lim. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PANCREATIC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-trans Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No detached the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was ...
autopsy
performed?
Yes 2X No page 2 certificate 1□ Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 ☐ Yes 2 No P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To the 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD.
32. Registrar's Signature TARIQ MAHMOOD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) FEB 2 State A SHELL Registrar

DHMH 17 Rev 1/2001

FEBRUARY

|                            |                                                                                                                                                                                                                                                                                                   |                  | For<br>State<br>Registrar                                                                | State of Maryla                                                                                |                                    | rtificate of                                                   |                                                         |                                   | eg. No. 2 0 0 8                          | 3 06257                                      |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------|---------------------------------------------------------|-----------------------------------|------------------------------------------|----------------------------------------------|
| F                          | Dhyoisi                                                                                                                                                                                                                                                                                           | A 113            | 1. Decedent's Name (First, Middle, Las                                                   |                                                                                                |                                    |                                                                |                                                         | 2. Date of Deat<br>Month          | h<br>Day Year                            | 3. Time of Death                             |
| 100                        | Physicia<br>/Medic                                                                                                                                                                                                                                                                                |                  | Betty                                                                                    |                                                                                                | n Ho                               | lley                                                           |                                                         | February                          | 27, 2008                                 | 1:20 A M                                     |
| )                          | Examin                                                                                                                                                                                                                                                                                            | er               | 4a. Facility Name (If not institution, give                                              |                                                                                                |                                    |                                                                | r Location of Death                                     |                                   | 4c. County of Dea                        |                                              |
|                            |                                                                                                                                                                                                                                                                                                   | *.               | Chesapeake Hosp  5. Social Security Number 6. S                                          |                                                                                                | s. last birthday)                  | LINE<br>If Under 1 Year                                        | hicum<br>If Under 24 Hrs.                               | 8. Date of Birth                  | Anne Arui                                | NGE I<br>irthplace (State or Foreign         |
|                            | Funeral<br>Director                                                                                                                                                                                                                                                                               |                  |                                                                                          | □ M 2□ F 81                                                                                    | Yrs.                               | Months Days                                                    | Hours Min.                                              | (Month, Day,<br>March 3           | Year) C                                  | Virginia                                     |
|                            | yland<br>yland<br>at                                                                                                                                                                                                                                                                              |                  | 10a. State 10b. County                                                                   | 10c. (                                                                                         | City, Town or Lo                   | cation                                                         |                                                         |                                   |                                          | 10d. Inside City Limits                      |
|                            | e Mau<br>3a-f sl<br>tified                                                                                                                                                                                                                                                                        | ctor             | Maryland Anne A                                                                          | rundel Pa                                                                                      | sadena                             |                                                                |                                                         |                                   |                                          | 1 ☐ Yes 2 ☐XNo                               |
|                            | th with th<br>23a or 28<br>ist be no                                                                                                                                                                                                                                                              | Funeral Director | 10e. Street and Number<br>7971 Tick Neck                                                 | Road                                                                                           |                                    | 10f. Zip Code<br>21                                            | 122                                                     | 1                                 | 0g. Citizen of What C<br>USA             | Country?                                     |
| 21215-0036                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | þ                | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Xidowed 4 ☐ Divorced              | 12. Was Decedent Ever in<br>Armed Forces?<br>1 ☐ Yes 2 No<br>If Yes, Give<br>Year or Dates:    |                                    | Was Decedent of Hif Yes, specify Cub<br>1 ☐ Yes 2☐ <b>X</b> No | dispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)  | 14. Race - Arr<br>Black, Wh<br>Specify:  |                                              |
| S<br>O                     | 72 ho<br>natur<br>lica I                                                                                                                                                                                                                                                                          | Be Completed     | 15. Decedent's Ec                                                                        | fucation                                                                                       | 16a. Deced                         | dent's Usual Occup                                             | oation<br>during most of work<br>d)                     | ting                              | 16b. Kind of Busines                     | s/Industry                                   |
| 2                          | vithin ne.                                                                                                                                                                                                                                                                                        | mple             | Elementary/Secondary (0-12)                                                              | College (1-4or 5+)                                                                             | Homem                              |                                                                | d)                                                      |                                   | Household                                |                                              |
| 5                          | illed v<br>Hygie<br>ther t                                                                                                                                                                                                                                                                        | ပ္ပိ             | 17. Father's Name (First, Middle, Last)                                                  | )                                                                                              | Homein                             | arei                                                           | 18. Mother's Name                                       |                                   |                                          |                                              |
| Maryland                   | d be i<br>ental<br>ked o                                                                                                                                                                                                                                                                          | To Be            | Hollis                                                                                   |                                                                                                | arst                               |                                                                | Ruth                                                    |                                   |                                          |                                              |
| 3                          | shoul<br>ind M<br>i marl                                                                                                                                                                                                                                                                          | ř                | 19a. Informant's Name/Relationship (                                                     |                                                                                                | T                                  | ng Address (Street                                             |                                                         | ral Route Number                  | UNKNOWY<br>; City or Town, State,        |                                              |
|                            | and 2<br>alth a<br>27 is<br>er trai                                                                                                                                                                                                                                                               |                  | Sharon L Chapman                                                                         | daughter                                                                                       | 7971                               | Tick Ne                                                        | ck Road Pa                                              | asadena                           | MD 21122                                 |                                              |
| ore                        | es 1 a of He fitem                                                                                                                                                                                                                                                                                |                  | 20a. Method of Disposition 1 → Burial 2 → Cremation 3 →                                  |                                                                                                | . Place of Dispo<br>cemetery, crei | sition (Name of<br>matory or other pla                         | ce)                                                     | Date                              | 20c. Location - City of                  | or Town, State                               |
| Ē                          | Pag<br>ment<br>ant: I                                                                                                                                                                                                                                                                             |                  | 4 □ Donation 5 □ Other (Specif                                                           | y)                                                                                             |                                    |                                                                | - 1                                                     |                                   | 8 Glen Bu                                |                                              |
| Baltimore,                 | permit<br>Depart<br>Import<br>any In                                                                                                                                                                                                                                                              |                  | 21. Signature of Funeral Ser (ce) Lice                                                   | see /                                                                                          | 22                                 | 2. Name and Addre                                              |                                                         |                                   | Funeral H<br>dena MD 21                  |                                              |
|                            | 1 / 20                                                                                                                                                                                                                                                                                            |                  | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only              | plications that caused the de                                                                  | eath. Do not ent                   | er the mode of dyi                                             | ng, such as cardiac                                     | or respiratory arr                | est,                                     | Approximate<br>Interval Between              |
|                            | Physician                                                                                                                                                                                                                                                                                         |                  | Immediate Cause (Final disease or condition                                              | C                                                                                              | 0040                               | store +                                                        | 1 1                                                     | a. lure                           |                                          | Onset and Death                              |
| 4                          | /Medical<br>Examiner                                                                                                                                                                                                                                                                              |                  | resulting in death)                                                                      | Due to (or as a cons                                                                           | equence o1:                        |                                                                |                                                         |                                   |                                          |                                              |
| ß                          | LAGIIIII                                                                                                                                                                                                                                                                                          | <u></u>          | Sequentially list conditions,                                                            | b. Due to for as a cons                                                                        | e luence off:                      |                                                                |                                                         |                                   |                                          |                                              |
|                            | nsit                                                                                                                                                                                                                                                                                              | mine             | cause. Enter Underlying<br>Cause (Disease or injury                                      | 540 (0 (0) 40 4 00 10                                                                          | or governor organization           |                                                                |                                                         |                                   |                                          |                                              |
| Ć,                         | rificate be executed ig physician and as the burial-transit                                                                                                                                                                                                                                       | Medical Examiner | that initiated events<br>resulting in death) Last                                        | Due to (or as a cons                                                                           | equence of):                       |                                                                |                                                         |                                   |                                          |                                              |
| 68760,                     | ysicia<br>ysicia                                                                                                                                                                                                                                                                                  | cal              |                                                                                          | _d                                                                                             |                                    |                                                                |                                                         |                                   |                                          |                                              |
|                            | rtifical<br>ng phy<br>as th                                                                                                                                                                                                                                                                       | Nedi             | IF FEMALE.                                                                               |                                                                                                |                                    |                                                                |                                                         |                                   |                                          |                                              |
| .O. Box                    | The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit                                                                                                                                 | Physician/N      | IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 2 No 9 ☐ Unknown | 23c. If yes, outcome pf pred<br>1 □ Live birth 2 □ F<br>4 □ Pregnant at time of<br>9 □ Unknown | etal death 3                       | □Ectopic pregnand □ Other (specify) _                          | ey .                                                    |                                   | 23d. Date of d<br>Month                  | lelivery<br>Day Year                         |
| <u>α</u>                   | ires that<br>signed by<br>d be deta                                                                                                                                                                                                                                                               |                  | Part II. Other significant conditions of                                                 | ^ ,                                                                                            |                                    | 1                                                              | ven in Part I.                                          |                                   |                                          | to the cause of death?  Probably 4 ☐ Unknown |
| COL                        | w required                                                                                                                                                                                                                                                                                        | lete             |                                                                                          |                                                                                                |                                    |                                                                | 7                                                       | 24a. Was a                        | n 24b. Were                              | autopsy findings available                   |
| E Re                       |                                                                                                                                                                                                                                                                                                   | Completed by     |                                                                                          |                                                                                                |                                    |                                                                |                                                         | autops                            | sy prior t<br>med? death<br>22 No 1 □ Yo | o completion of cause of                     |
| Zii                        | Attending Physician: The roleath.<br>ector: After this certificate i by the funeral director, pag                                                                                                                                                                                                 | Be               | 25. Was case referred to medical examiner?                                               | Hospital:                                                                                      |                                    | Ot                                                             | 26. Place of Deather:                                   |                                   |                                          | 1\                                           |
| ō                          | Phys<br>r this<br>ral dii                                                                                                                                                                                                                                                                         | . To             | 1 ☐ Yes 2 ☐ No<br>27. Manner of Death                                                    | 1 ☐ Inpatient 2                                                                                | ER/Outpatier                       | " POA                                                          | 4 Li Nursing H                                          |                                   | ence 6 Other (S <sub>k</sub>             | pecify) To spree                             |
| 0                          | ading<br>th.<br>: Afte<br>e fune                                                                                                                                                                                                                                                                  | tion             | 1 ☐ Accident 5 ☐ Pending investigation                                                   | (Month, Day Year                                                                               | ) Injury                           | f 28c. Inju<br>Wo<br>M 1 ☐                                     | rk?<br>]Yes 2 □ No                                      |                                   |                                          | 11045~                                       |
| Division or Vital Records, | or Atter<br>after dea<br>Director<br>in by the                                                                                                                                                                                                                                                    | Certification:   | 3 Suicide 6 Could not b<br>4 Homicide determined                                         |                                                                                                |                                    | reet, factory, office                                          |                                                         | 28f. Location (Si<br>City or Town |                                          | Rural Route Number,                          |
| _                          | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.                                                                                                                                  |                  | (Check only 2 Medical Example 12 Medical Example 2                                       | nysician: To the best of my l<br>miner: On the basis of exam                                   |                                    |                                                                |                                                         |                                   |                                          |                                              |
|                            | To the I within 24 To the I complet                                                                                                                                                                                                                                                               | Medical          | one)  29b. Signature and title of certifier                                              | and manner stated.                                                                             | 7                                  | 29c. Licen                                                     | se pymber                                               | 2                                 | 29d. Date signed (Mo                     | onth, Day, Year)                             |
|                            | F3F8                                                                                                                                                                                                                                                                                              |                  | 17/12                                                                                    | ~ ////d                                                                                        | m                                  | 7 /                                                            | 13/15                                                   | /                                 | Februs                                   | 77700f                                       |
| 2                          | T                                                                                                                                                                                                                                                                                                 |                  | 30. Name and address of person who                                                       | compreted cause of death (                                                                     | tem <u>23a)</u> (Type,             | Print)                                                         | -:+0                                                    | 0 /                               | (). B                                    | 067210/1                                     |
|                            | Sta                                                                                                                                                                                                                                                                                               |                  | 31. Date filed (Month, Day, Year)                                                        | 32 Registrar's Signature                                                                       | gnature                            | acts)                                                          | Bild.                                                   | U)Cire)                           | JAN MIN                                  | 1. M. C (00)                                 |
|                            | Registi                                                                                                                                                                                                                                                                                           | ar               | FEB 2 9 2                                                                                | 008 1000                                                                                       | 18 18 P                            | CO CO                                                          |                                                         |                                   |                                          |                                              |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U J 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 323 AM Lillie Hayward ebruary 24 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 2000 Tan 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2 □ F Months Days Hours Min Director No.Carolina 219-28-4727 Aug 28, 1933 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐¥es 2 ☐ No Director N/A **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 6201 Lock Raven Blvd. #312 21239 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Southern Rental Presser permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, <u>Il</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Hayward David Hayward ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6201 Lock Raven Blvd.-#312 Baltimore, Maryland 21239 Maria Ware Itimóre. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Murial 2 ☐ Cremation 3 ☐ Removal from State 03/01/08 Lansdowne, Maryland 4 Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 22. Name and Address of Facility 21. Sign of Funeral Ser ic Licen Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 ications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Aset/and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (r as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 🗌 Yes 2 □ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 No betes After this certificate 2 No 1 ☐ Yes or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA Certification: To 1 🔲 Inpatient funeral 27. Mann of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) s after dea... ral Director: Aftr Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 display in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. (Check only one) 29b. Signatur

State

Registrar

death (Item 23a) (Type, Print)
Saman Tar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** BERNARD PSO FRANKLIN 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE BURN CENTER S AUTIMORE HOPKINS If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** 216-30-201 Days Hours Min 1 2 M 2 □ F Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō U.S.A. 21401 1045 Skidmore Drive or Items 23a Funerai 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: " Black þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Annapolis Cleaning Service Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Maintenance Supr 12 of Health and Mental Hygie item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) . . . 17. Father's Name (First, Middle, Last) Be Helen Harris Theodore Harris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 560 C New Scotland Avenue Albany, New York 12208 Donna Robinson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/29/08 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. of Funeral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a, Part I. Enter the disease shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Physician EPIDERMAL /Medical Due to (or as a consequence of) **Examiner** PSIS Sequentially list conditions, ue to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transli Due to (or as a consequence of): Box 68760. Physician/Medical as the t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 No 3 Probably 4 Unknown I CIENCY Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Division of Vital Records, Hospitel or Attending Physician:

Certification:

Medicai

State

Registrar

death. Director: filled in by the To the Hospitel o within 24 hours af To the Funerel D

Manner of Death 1 Natural

29a. Certifier

2 Accident 3 Suicide 4 Homicide

investigation Could not be determined

5 Pending

Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Tyes

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of

MEDICAL DOLTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIUSAM 1BOUHASSOM

31. Date filed (Month, Day, Year) FEB 2 9 2008



Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 687605

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran signed by the ald be detached for s certificate has t irector, page 2 s To the Hospital or Attending Physician: this s after death.

I Director: After this d in by the funeral d within 24 hours aft

To the Funeral DI

completely filled in

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

29d. Date signed (Month, Day, Year) 02-25-08

Annagolis

|                        |                                                                                                                                                                                            | 1                                         | State of Maryland / Department of Health and Mer    = State Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ntal Hygien<br>Reg. No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2000 00201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
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|                        |                                                                                                                                                                                            |                                           | Decedent's Name (First, Middle, Last)     2.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Date of Death<br>Month Da                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 3. Time of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                        | Physicia<br>/Medic                                                                                                                                                                         |                                           | Catherine Dolores Holland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | BRUBRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 19 2008 11.137. M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                        | Examin                                                                                                                                                                                     | er                                        | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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                         | County of Death  WHE ARUNDEL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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|                        |                                                                                                                                                                                            | 6                                         | ALTIMORA WASHINGTON MEDICAL CENTRE GUEN SURMI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Data of Birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 9. 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|                        | be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or Items 23a or 28a-f show event, the Madical Examinat must be notified at                   | Funeral Director                          | 0010 Ricellic Hwy, Rm 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 14. 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| 20                     | 72 ho                                                                                                                                                                                      | Completed                                 | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| 2                      | filed w<br>Hygier<br>kther th                                                                                                                                                              | S                                         | 8 HOMEMIAKEL  17. Father's Name (First, Middle, Last)  18. 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| Maryland 21215-0036    | s 1 and 2 should be !<br>Health and Mental I<br>item 27 is marked o<br>other traumatic eve                                                                                                 | ٩                                         | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural R                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| ē,                     | es 1 an<br>of Heal<br>f item 2<br>r other                                                                                                                                                  |                                           | 20a. Method of Disposition 20b. Place of Disposition (Name of Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 9 20c.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Location - 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| alt                    | permit. Pag<br>Dep rtment<br>Important:<br>any injury c                                                                                                                                    |                                           | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G. J.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| ш                      |                                                                                                                                                                                            |                                           | 23a. Part . Enter the disease, or or molications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List hip one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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|                        | Examiner                                                                                                                                                                                   |                                           | Due to (or as a consequence of):  MRTASTATIC VALVAR CA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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|                        |                                                                                                                                                                                            | -e-                                       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                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| o,                     | e exe<br>ian ar<br>urial-tı                                                                                                                                                                | EX                                        | resulting in death) Last Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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If yes, outcome of pregnancy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23d. 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Was decedent pregnant in the past 12 months?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23d. 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Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1  Yes  24a. 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Manper of Death   Natural   5   Pending                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1  Yes  24a. 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Certifier (Check only 2   Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and 2   Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and 2   Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1 Yes  24a. 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Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify) jury occurred  and Number or Rural Route Number, ate)  (s) and manner as stated.  (s) and manner as stated.  Individually the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of th |
| of Vital Records, P.O. | ding Physician: The law requires that the death certifi<br>n.<br>After this certificate has been signed by the attending<br>funeral director, page 2 should be detached for use as         | Medical Certification; To Be Completed by | 236. Was decedent pregnant in the past 12 months? 1   Yes 2   ZMNo 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  25. Was case referred to medical examiner? 1   Yes 2   No   Hospital: 1   Impatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home    24a. Was an autopsy performed; 1 Yes 2 The Check only one) 5 Residence d. Describe how in f. Location (Street City or Town, St. at the time, date a second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s | Month Day Year  Do use contribute to the cause of death?  2 No 3 Probably 4 Monknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify) jury occurred  and Number or Rural Route Number, ate)  (s) and manner as stated.  (s) and manner as stated.  Individually the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of th |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1:20 AMM February 24, 2008 /Medical Charles Giles Harris 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6807 Trexler Road Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1⊠M 2□F 86 Director 01/03/1922 MS 577-16-3941 Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d, inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Director Lanham Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or a limportant or other traumatic event, the Medical Examiner must be a USA 20706-Funeral 6807 Trexler Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1943 - 46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Business Elementary/Secondary (0-12) College (1-4or 5+) **Business Consultant** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Juanita Newton ၉ Everett Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6807 Trexler Road Lanham, MD 20706-Betty Harris/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State FEB. 29 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M00382 Stoh D Xohmun Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to ( r) s a consequence of): HEAST /Medical Examiner OFONDER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and the burial-transit Due to (or as a consequence of) Completed by Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dead 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) P.O. 1 signed by the a 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division or Vital Records, 1 | Yes 2 | No 3 | Probably 4 | Unknown it usms 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed 1☐ Yes 2 No page this certificate 2 No 1 ☐ Yes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To funeral 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manper of Death 28c. Injury at Work? After 1 Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (item 23a) (Type, Print) LESKUSK #200, Largo, MD 31. Date filed (Month, Day, Year) edistrar's Signature

State Registrar

FEB 2 9

2008

|                                      |                                                                                                                                                                                                                   |                | For<br>State<br>Registrar                                                                                   | State of Marylan                                            |                                | artment of F<br>rtificate of                  |                                           |                                         | giene<br>Reg. No. 20               | 0.8                        | 06263                                              |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------|-----------------------------------------------|-------------------------------------------|-----------------------------------------|------------------------------------|----------------------------|----------------------------------------------------|
| a —                                  | Physici                                                                                                                                                                                                           | an             | Decedent's Name (First, Middle, Last)                                                                       |                                                             |                                |                                               |                                           | 2. Date of Dea                          |                                    | Year                       | 3. Time of Death                                   |
|                                      | /Medic                                                                                                                                                                                                            |                |                                                                                                             | H. Douglas Ha                                               | 11                             |                                               |                                           | Februa                                  | ry 26, 2                           | 2008                       | 3:20PM M                                           |
|                                      | Examin                                                                                                                                                                                                            | er             | 4a. Facility Name (If not institution, give s.                                                              | ,                                                           |                                |                                               | r Location of Death                       | 1                                       | 4c. County                         |                            |                                                    |
| - de                                 | Funeral                                                                                                                                                                                                           |                | 794 Tulan<br>5. Social Security Number 6. Sex                                                               | Place 7. Age (In yrs.                                       | last birthday)                 | If Under 1 Year                               | ockville<br>If Under 24 Hrs.              | 8. Date of Birt                         | h                                  | ontgoi<br>9. Birthpla      | mery<br>ace (State or Foreign                      |
|                                      | Director                                                                                                                                                                                                          |                | 213-22-4843                                                                                                 | M 2□F 80                                                    | Yrs.                           | Months Days                                   | Hours Min.                                | October                                 | y, Year)                           | Counti                     | aryland                                            |
| pue                                  | 8                                                                                                                                                                                                                 |                | Usual Residence of Decedent  10a. State 10b. County                                                         | 10c Cib                                                     | y, Town or Lo                  | cation                                        |                                           |                                         |                                    |                            | d. Inside City Limits                              |
| Maryla                               | f sho                                                                                                                                                                                                             | or             |                                                                                                             |                                                             | y, 10W1101 Ec                  |                                               |                                           |                                         |                                    | 10                         | 1 X Yes 2 □ No                                     |
| the l                                | r 28a-<br>notif                                                                                                                                                                                                   | Director       | Maryland Montgo                                                                                             | omery                                                       |                                | Rockv:<br>10f. Zip Code                       | ille                                      |                                         | 10g. Citizen of V                  | hat Count                  | ry?                                                |
| th wit                               | 23a o<br>Ist be                                                                                                                                                                                                   | al D           | 794 Tulan                                                                                                   | e Place                                                     |                                |                                               | 20850                                     |                                         | Un                                 | ited :                     | States                                             |
| ar dea                               | tems<br>er mi                                                                                                                                                                                                     | Funeral        |                                                                                                             | <ol><li>Was Decedent Ever in U.<br/>Armed Forces?</li></ol> | S. 13.                         | Was Decedent of H                             | lispanic Origin? (S<br>an, Mexican, Puert | pecify Yes or No<br>o Rican, etc.)      |                                    | e - America<br>k, White, e | n Indian,                                          |
| rs afte                              | l", or i<br>kamin                                                                                                                                                                                                 | by F           | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced                                                      | 1 X Yes 2 □ No<br>If Yes, Give<br>Year or Dates: 1.π.τ.τ    |                                | 1 □ Yes 2 <b>X</b> No                         | Specify:                                  |                                         | Specify                            | :                          |                                                    |
| 2 hou                                | atura<br>cal E                                                                                                                                                                                                    | ted            | 15. Decedent's Educ                                                                                         | ation WW I                                                  | 16a. Dece                      | dent's Usual Occup                            | ation                                     |                                         | 16b. Kind of Bu                    |                            | hite<br>ustry                                      |
| thin 7                               | e.<br>Medi                                                                                                                                                                                                        | Completed      | (Specify only highest grade Elementary/Secondary (0-12)                                                     | College (1-4or 5+)                                          | (Give<br>life.                 | kind of work done<br>DO NOT use retired       | during most of wor<br>d)                  | king                                    |                                    |                            | County                                             |
| led wi                               | lygien<br>her th<br>it, the                                                                                                                                                                                       |                |                                                                                                             | 4                                                           |                                | Adminis                                       |                                           |                                         | Public                             | e Scho                     | ools                                               |
| l be fil                             | ntal H<br>ed otl<br>even                                                                                                                                                                                          | Be             | 17. Father's Name (First, Middle, Last)                                                                     |                                                             |                                |                                               | 18. Mother's Nan                          |                                         |                                    |                            |                                                    |
| should                               | nd Me<br>mark<br>matic                                                                                                                                                                                            | 욘              | Lyd  19a. Informant's Name/Relationship (Typ                                                                | ie N. Hall e. Print)                                        | 19b. Mailir                    | ng Address (Street                            | and Number or Ri                          |                                         | Rebecca                            |                            |                                                    |
| nd 2 s                               | althar<br>27 Is<br>ertrau                                                                                                                                                                                         |                | Joanne S. Hall/                                                                                             | ,                                                           |                                | Tulane                                        |                                           |                                         |                                    |                            | ,                                                  |
| es 1 a                               | of He                                                                                                                                                                                                             |                | 20a. Method of Disposition                                                                                  | 20b. P                                                      | lace of Dispo                  | sition (Name of matory or other place         | ce)                                       | Date                                    | 20c. Location -                    |                            |                                                    |
| Pag                                  | ment: Bant: Bury o                                                                                                                                                                                                |                | 1 ☐ Burial 2 【Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)                                          | movarifori State                                            | lontgon                        | nery<br>Trium Inc                             | Feb:                                      | ruary<br>2008                           | Bethes                             | sda, N                     | Maryland                                           |
| ermit                                | Department of Health and Mental Hygiene.<br>Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once. |                | 21. Signature of Funeral Service License                                                                    |                                                             | 22                             | 2. Name and Addre Rockvill                    | ss of Facility Role.                      | ert A.<br>300 West                      | Pumphrey<br>Montgoi                | y Fund                     | eral Home/<br>Avenue                               |
|                                      |                                                                                                                                                                                                                   |                | 23a Part 1 Enter the disease of warm                                                                        | M0033                                                       | 5                              | Rockvill                                      | e, Maryla                                 | and 2085                                | 0-2805                             |                            |                                                    |
| Dh                                   | ysician                                                                                                                                                                                                           |                | 23a. Part1. Enter the disease or compenshock, or heart failure. List only one Immediate Cause (Final        |                                                             |                                |                                               | ig, such as cardiac                       | or respiratory at                       | rest,                              |                            | Approximate<br>Interval Between<br>Onset and Death |
|                                      | Vedical                                                                                                                                                                                                           |                | disease or condition resulting in death)                                                                    | Urothelial Due to (or as a consequ                          |                                | er                                            |                                           |                                         |                                    |                            | l Year                                             |
| Ex                                   | aminer                                                                                                                                                                                                            |                | Sequentially list conditions b.                                                                             |                                                             |                                |                                               |                                           |                                         |                                    |                            |                                                    |
| / po                                 | sit                                                                                                                                                                                                               | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ                                     | uence of):                     |                                               |                                           |                                         |                                    |                            |                                                    |
| xecut                                | and<br>al-tran                                                                                                                                                                                                    | Examiner       | that initiated events c. resulting in death) Last                                                           | Due to (or as a consequ                                     | uence of):                     |                                               |                                           |                                         |                                    |                            |                                                    |
| ificate be executed                  | physician and<br>the burial-transit                                                                                                                                                                               | edical E       |                                                                                                             |                                                             |                                |                                               |                                           |                                         |                                    |                            |                                                    |
| rtificat                             | - 02                                                                                                                                                                                                              | /ledi          |                                                                                                             |                                                             |                                |                                               |                                           |                                         |                                    |                            |                                                    |
| ath ce                               | attending<br>I for use a                                                                                                                                                                                          | hysictan/M     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?                                                | c. If yes, outcome pf pregna<br>1 ☐ Live birth 2 ☐ Feta     |                                | JEctopic pregnancy                            | /                                         |                                         |                                    | e of deliver               | •                                                  |
| he de                                | by the attached for                                                                                                                                                                                               | ysici          | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                                                                               | 4□Pregnant at time of d<br>9□Unknown                        | eath 5                         | Other (specify)                               | <u> </u>                                  |                                         | Mo                                 | nun L                      | Day Year                                           |
| The law requires that the death cert | 8 8                                                                                                                                                                                                               | <u>a</u>       | Part II. Other significant conditions conf                                                                  | ributing to death but not resu                              | ulting in the u                | nderlying cause giv                           | en in Part I.                             | 23e. Did to                             | obacco use contr                   | ribute to the              | e cause of death?                                  |
| quires                               | 5 8                                                                                                                                                                                                               | d by           |                                                                                                             |                                                             |                                |                                               |                                           | 1 🗆 1                                   | ∕es 2 No                           | 3 Proba                    | ably 4∭Unknown                                     |
| aw re                                | is been sig                                                                                                                                                                                                       | Completed      |                                                                                                             |                                                             |                                |                                               |                                           | 24a. Was                                | an 24b.\                           | Vere autop                 | sy findings available                              |
|                                      | ate ha                                                                                                                                                                                                            | Com            |                                                                                                             |                                                             |                                |                                               |                                           | autor<br>perfo<br>1□ Yes                | rmed?                              | death?                     | pletion of cause of<br>2□ No                       |
| cian:                                | ertific<br>actor,                                                                                                                                                                                                 | Be             | 25. Was case referred to medical examiner?                                                                  |                                                             | -                              |                                               |                                           | th (Check only o                        |                                    |                            |                                                    |
| Phys                                 | this cral dire                                                                                                                                                                                                    | 2              | 1 ☐ Yes 2 No                                                                                                | ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury              | ·                              |                                               | 4 LI Nursing H                            | ome 5 X Resid                           |                                    |                            | )                                                  |
| gulp.                                | h.<br>: After<br>fune                                                                                                                                                                                             | tion           | 1 X Natural 5 □ Pending 2 □ Accident investigation                                                          | (Month, Day Year)                                           | 28b. Time o<br>Injury          | Wor                                           | yat<br>k?<br>Yes 2 ∐ No                   | 280. Describe r                         | now injury occurr                  | ea                         |                                                    |
| Atter                                | r deat<br>ector<br>by the                                                                                                                                                                                         | Certification: | 3 Suicide 6 Could not be determined                                                                         | 28e. Place of injury - At ho                                |                                |                                               |                                           | 28f. Location (S                        | Street and Numb                    | er or Rural                | Route Number,                                      |
|                                      | ours after death.  eral Director: After this certificate has filled in by the funeral director, page 2                                                                                                            | Cert           |                                                                                                             | building, etc. (Specify                                     |                                |                                               |                                           | City or Tou                             | ,                                  |                            |                                                    |
| Hospital or Attending Physician:     | within 24 hours after death.  To the Funeral Director: After completely filled in by the fur                                                                                                                      | ical           | 29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examin                                    | ician: To the best of my kno<br>er: On the basis of examina | wledge, deat<br>tion and/or in | h occurred at the tir<br>vestigation, in my c | me, date and place                        | e, and due to the<br>arred at the time, | cause(s) and ma<br>date and place, | nner as sta<br>and due to  | ated.<br>the cause(s)                              |
| o the                                | o the                                                                                                                                                                                                             | Medical        | 29b. Signature and title of certifier                                                                       | and manner stated.                                          |                                | 29c. Licens                                   |                                           |                                         | 29d. Date signed                   |                            |                                                    |
|                                      |                                                                                                                                                                                                                   |                | I fail                                                                                                      | hamle                                                       | I mo                           |                                               |                                           | 1                                       |                                    | ,                          | ,                                                  |
| 16                                   | 5+1                                                                                                                                                                                                               |                | 30. Name and address of person who cor                                                                      | npleted cause of death (Item                                | 23a) (Type,                    | Print)                                        | D0061083                                  | )                                       | Febru                              | ary 2                      | 7,_2008                                            |
| ,                                    |                                                                                                                                                                                                                   |                | Paul Thambi, M.D.                                                                                           | 9707 Medical                                                | Cente                          |                                               | #300, Ro                                  | ockville                                | , Maryla                           | and 20                     | 0850                                               |
|                                      | Sta                                                                                                                                                                                                               | te             | 31. Date filed (Month, Day, Year)                                                                           | 32. Registrar's Signa                                       |                                | X TOWN                                        |                                           |                                         |                                    |                            |                                                    |

Division or Vital Records, P.O. Box 68760,

within 24 hours after death To the Funeral Director: filled in by To the Hospital completely

DHMH 17 Rev 1/2001

29b. Signature and title of certifie

(Check only

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D64296

February 23, 2008

1500 Forest Glen Rd., Silver Spring, Maryland 20910 Richard Nguyen, M.D., 31. Date filed (Month, Day, Year)

State Registra

Medical

FEB 2008 9



|                                                                                                                                                                                                                                                                                   | 1- State of M                                                                                                           | -                                                           | artment of Health<br>ertificate of Deat                                       | 6                                                          | 2008 0526                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------|
| Physician<br>/Medical                                                                                                                                                                                                                                                             | Decedent's Name (First, Middle, Last)     August Bernard Janda                                                          |                                                             |                                                                               | 2. Date of Deat<br>Month<br>February                       | 26 2008 13:13                                                                        |
| Examiner                                                                                                                                                                                                                                                                          | 4a. Facility Name (If not institution, give street and number 200 E Clifford Lane                                       | r)                                                          | 4b. City, Town, or Location<br>Forest Hill                                    |                                                            | 4c. County of Death<br>Harford County                                                |
| uneral<br>irector                                                                                                                                                                                                                                                                 | 5. Social Security Number 6. Sex 1 M № 2 ☐ F 7. A                                                                       | lge ( <i>In yrs. last birthday</i><br>84 Yrs.               | Months Days Hours                                                             | er 24 Hrs. 8. Date of Birth (Month, Day, November          | 9. Birthplace (State or Fore<br>Country) Paltimore, Maryl                            |
| show                                                                                                                                                                                                                                                                              | Usual Residence of Decedent  10a. State 10b. County  Maryland Harford County                                            | 10c. City, Town or L                                        |                                                                               |                                                            | 10d. Inside City Lin<br>1 ☐ Yes Z                                                    |
| be notified                                                                                                                                                                                                                                                                       | 10e. Street and Number 200 E. Clifford Lane                                                                             |                                                             | 10f. Zip Code<br>21050                                                        |                                                            | Og. Citizen of What Country?                                                         |
| Department of needing and warehold of their than "natural", or items 23a or 28a-f show mortants if item 27 is marked other than "natural", or item 27 is a natural or other traumatic avent, it a Medical Examinat must be notified at once.  To Be Completed by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deceden Armed Forces 1 MYes 2 If Yes, Give | s?<br>] No                                                  | Was Decedent of Hispanic ( If Yes, specify Cuban, Mexic  1 ☐ Yes 2 No Specify | can, Puerto Rican, etc.)                                   | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: White                  |
| t. If a Medical E                                                                                                                                                                                                                                                                 | 15. Decedent's Education<br>(Specify only highest grade completed)  Elementary/Secondary (0:12)  College (1-40          | (Giv<br>life.                                               | edent's Usual Occupation e kind of work done during m DO NOT use retired)     |                                                            | 16b. Kind of Business/Industry  B•G•E•                                               |
| avent, Its                                                                                                                                                                                                                                                                        | 12 N/A 17. Father's Name (First, Middle, Last) August T. Janda                                                          | Seriic                                                      |                                                                               | ther's Name (First, Middle, on R. Sporsal                  |                                                                                      |
| 27 ia marke<br>traumatic<br>To                                                                                                                                                                                                                                                    | 19a. Informant's Name/Relationship (Type, Print) Mrs. Rosemary Tyler (Daughter)                                         | 19b. Mai<br>1802                                            | ling Address (Street and Num<br>Belview Drive, F                              | orest Hill, Mary                                           | r, City or Town, State, Zip Code)<br>yland 21050                                     |
| nt: If itam.                                                                                                                                                                                                                                                                      | 20a. Method of Disposition  1 ☐ Burial 2 ③Cremation 3 ☐ Removal from Stat  4 ☐ Donation 5 ☐ Other (Specify)             |                                                             | position (Name of ematory or other place)                                     | Feb. 28,2008                                               | 20c. Location - City or Town, State Forest Hill, Maryland                            |
| Importa<br>any inju<br>once.                                                                                                                                                                                                                                                      | 21. Signature of Funeral Service Licensee                                                                               | F                                                           | 22. Name and Address of Fa<br>wans Funeral Char<br>Newport Drive,             | rel & Cremation (                                          | Center — Bel Air<br>vland 21050                                                      |
| attending physician and attending physician and Itor use as the burial-transit and clan/Medical Examiner                                                                                                                                                                          | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c Due to (or a         | as a consequence of): as a consequence of): me of pregnancy |                                                                               |                                                            | 23d. Date of delivery                                                                |
| signed by the attending be detached for use as be detached for use as by Physician/Me                                                                                                                                                                                             | in the past 12 months?  1   Yes 2   No 9   Unknown                                                                      | t at time of death 5                                        | □ Other (specify)                                                             |                                                            | Month Day Yea                                                                        |
| b ed bed                                                                                                                                                                                                                                                                          | Part II. Other significant conditions continuously to death                                                             | h but not resulting in the                                  | underlying cause given in Pa                                                  | 23e. Did to                                                | obacco use contribute to the cause of deal                                           |
| certificate has been si<br>rector, page 2 should                                                                                                                                                                                                                                  |                                                                                                                         |                                                             |                                                                               | 1 ☐ Yes                                                    | prior to completion of caude death?  2 No 1 Yes 2 No                                 |
| After this funeral di                                                                                                                                                                                                                                                             |                                                                                                                         | 1                                                           | ient 3 DOA Other: 4 of 28c. Injury at Work?  M 1 Yes 2                        | 28d. Describe h                                            | dence 6 Other (Specify)  now injury occurred  Street and Number or Rural Route Numbe |
| within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical                                                                                                                                                                               |                                                                                                                         | is of examination and/or                                    | eath occurred at the time, date investigation, in my opinion,                 | e and place, and due to the<br>death occurred at the time, | cause(s) and manner as stated. date and place, and due to the cause(s)               |
| To the comple                                                                                                                                                                                                                                                                     | Benarlet She NO.                                                                                                        | NME                                                         | 29c. License numb                                                             |                                                            | 29d. Date signed (Month, Day, Year)                                                  |
|                                                                                                                                                                                                                                                                                   | 30. Name and address of person who completed cause of RERNARD J. VUKNA MA.)                                             | of death (Item 23a) (Type) ME 16/4 CI                       |                                                                               | 1. BEL AIR M                                               | d 2105                                                                               |
| - 1                                                                                                                                                                                                                                                                               |                                                                                                                         | istrar's Signature                                          |                                                                               |                                                            |                                                                                      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death :00 Am Day Month Year **Physician** 200 28 hrus /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner emont Itimore 9 Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Number **Funeral** Days Hours 1**X**M 2□F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 XYes 2 ☐ No Funeral Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a mont . Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status other traumatic event, the Medical Examiner 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me once. College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ohnSon 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Wife) 212 tremont 20b. Place of Disposition cemetery, cremator 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10 2. Name and Address of Facility Joseph L. Russ 2722 W. North 21. Signature of Funeral Service Licen uneral 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** W C110 661 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached for ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral 28c. Injury at Work? 27. Manner of eath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Year (Month, Day Injury 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 569 hinles (? 6 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First Middle, Last) Month Year Physician 2008 OZ /Medical 4c. County of Death acility Name (If not institution, give street and number) Town, or Location of Death Examiner N/A MOR If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Yeal Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□M 2□₹ Maryland Director 214-44-2744 64 Nov 27, 1943 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 ☐ No **Baltimore** N/A Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21217 "natural", or Items 23a 2905 Walbrook Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Itel 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ Nox Baltimore, Maryland 21215-0036 Specify. Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Jones Samuel Allen ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2905 Walbrook Avenue Baltimore, Maryland 21216 Mary Jones Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cyemation 3 ☐ Removal from State 03/03/08 Catonsville, Maryland 4 Donation 5 Other (Specify) Metro Crematory, Inc. Sign 22. Name and Address of Facility of Funeral Servi Estep Brothers Funeral Service, P. 1300 Futaw Place Baltimore, Md 2 Approximate Interval Between Onset and Death cations that cau nejcause on each 23a. Part1. Enter the disease shock, or heart failure. d the de Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Por in the past 12 months? Month Day Year 5 Other (specify) 2 No the detached 9 Tunknown signed by 23e. Did tobacco use contribute to the cause of death? of resulting in the underlying cause given in Part I. Part II. Other significant conditions con \$ page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed been s 246. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 7 No Yes Physician: 25. Was case referred to examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 21 LHC 1 Dimpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury After t Hospital or Attending (Month, Day Year) 5 Pending investigation 1 D Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number of per Registrar's Signature State 9 2008 Registrar

Examiner The law requires that the death certificate be executed physician a the burial-1 Division or Vital Records, P.O. Box 68760 attending pl certificate has been si ector, page 2 should Hospital or Attending Physician: director, eral Director: After th filled in by the funeral death. after death Director: 24 hours a

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

If item 27 is marked other than "natural", or items 23a or or other traumatic event, the M dical Examiner must be r

permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked oth any Injury or other traumatic event

**Physician** 

/Medical

Examiner

Physician/Medical

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Completed

Be

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Director

by Funeral

Completed

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Tohnson

27. Manner of Death 1 ☑ Natural Certification: 2 Accident 3 Suicide 4 Homicide 29a. Certifier Medical (Check only within 24 and manner stated. 29b. Sig ature and title of certifier 29c. Liçense number 28d Date signed (Month, Day, Year) 30 Name and address of person who comple ed cause of death (Item 23a) (Type, Print) rive Glen Burnie LABA Hospital 32. Registrar's Signature 31. Date filed (Month, Day, State 2008 Registrar ORIGINAL:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** AM 5:15 torrest Randolph Kellam 27, February 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Future Care Homewood Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) April 7, 1940 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 ☐ F 140-30-6907 **Director** New Jersey Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 St. Paul 3501 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 No If Yes, Give Year or Dates: 1954 -1964 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales & Maintenance Maintenance 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Otto Kellam Minerva P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Lincoln Drive Cheryl Orszulak / Doughter 20a. Method of Disposition Flanders, NJ 07836 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Ardent Cremations February 28, 2008 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ardent Cremations 21. Signature of Funeral Service Licensee Fama C. Hardes Q 7522 Connelley Drive Sult N. Hanover, MD M-01197 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER OF Unknow **Physician** (211 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4⊡Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2X No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No T<sub>o</sub> 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after use.....

To the Funeral Director; A 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 127 103 D8059026 Dalject School MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) alject Saluje 3612 Fall Belt MO W 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 29

2008▶

Grant Co

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** EVELYN FEBRUARY 25, 2008 KUMMET 7:30 A /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗙 F Days Hours Director 216-18-1150 83 Maryland June 15,1924 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at Harford Forest Hill MD. 1 □Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Forest Valley Drive 21050 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZX No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) At Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 Is marked ott Ernest Barnes Mabel Mauk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8326 Old Harford Rd. Baltimore, MD. 21234 Dorothy A. Sell/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. Union Cemetery 1X Burial 2 □Cremation 3 □Removal from State 03/05/08 Bedford, Pennsylvania 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services aliene 8800 Harford Rd. Parkville, MD. 21234 ach - au 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** melazlate /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 25, 200 P32295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DAVID DUNN

31. Date filed (Month, Day, Year)

FEB 2

DHMH 17 Rev 1/2001

BEL AIR, MD.

21014

615 W. MACPHAIL ROAD

2008

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

2008

Greece

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 No

1. Decedent's Name (First, Middle, Last) **Physician** 01900 azanlian /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** tosata Balti more Baltimore City HO Johns If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 12/01/1926 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F 81 Director 119-16-9208 Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location ia or 28a-f show t be notified at Director Silver Spring MD Montgomery filed within 72 hours after death with the l Hygiene. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20904-USA ms 23a 1517 Ainsley Road Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11 Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No \$ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Business Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur 12 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental (UNKNOWN) Entzag Kazanjian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S 1517 Ainsley Road Silver Spring, MD 20904-Gloria Kazanjian/Wife 27 Department of Health Important: If item 27 any injury or other tr 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Mar 1 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc.2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Mar 21. Signature of Funeral Service-bicensee let Tolmer Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 10/0 Multo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed Ischemic and burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 21 No 1 ☐ Yes Completed peen 24a, Was an page 2 s certificate has autopsy performed? Yes 2 No Division or Vital 25. Was case referred to medica examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient 1 Tes 2[2] No 2 ER/Outpatient 3 DOA ၉ this funeral After 1 Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

23d. Date of delivery 23e Did tohacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier

State

the

filled in by

completely

Medical

Registrar

and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** ELIZABETH MARY KOVARIK 7:30 PM<sup>M</sup> **FEB** 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE GILCHRIST CENTER 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 🕶 F 141-24-2482 75 Director 4-18-1932 New Jersey Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2√CXNo Directo Maryland Baltimore Baltimore County 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with t ment of Health and Mental Hygiene.
Ant: If item 27 is marked other than "natural", or items 23a or 2 and 20 or or or or or other than with the Medical Examiner must be not yet. 1 Avery Court 21237 Completed by Funeral **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XXNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sit & Stitch 12 yrs. Secretary/Sales Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Leonard Davenport Estella P. Pulis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avery Court Baltimore, Md. Charles Kovarik (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I-Important: If ite any injury or oti X Burial 2 □ Cremation 3 □ Removal from State Zion Church Cemetery | 3-3-2008 Baltimore, Md. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, 21. Some ture of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final STROKE Physician DAUS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, physician ast IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by BREAST CANCER 1 Tes 2 No 3 Probably 4 Unknown CHRONIC WOUNDS 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate ha To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury 1 ☐ Yes 2 ☐ No ✓ □ Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide tipe certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated 29b. Signature and title of cortific 29c. License number 29d. Date signed (Month, Day, Year) D64395 FEBRUARY 27, 2008 iΟ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19565 NCHARLESSTT SWITE ZOG BALTIMORE, MO 21204 DANIEUR DOBERMAN, MO 31. Date filed (Month, Day, Year) 32. Registra Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2352 PM 25 Η. Kirby George 2008 2 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore FRANKLIN SQUARE HOSPITAL CENTER Rosadale 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 □ F 578-50-9570 69 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore Middle River 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 904 Fusrlage Avenue 21220 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodial Department Baltimore County permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the one. 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be ( Fred Kirby Irene Wright ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 904 Fuselage Ave. Baltimore MD 21220 Effie V. Kirby / wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Bayview Crematory FEB-29.200 1 ☐ Burial 2X Cremation 3 Removal from State Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signatural Funeral Service Licensee atuck Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hemorrhage Immediate Cause (Final **Physician** intracranial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9□Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 ☐ Yes 2 No 2 7 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 (Month, Day Year) Hospital or Attending 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident 24 hours after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2008 30 Name and address of person who completed cause of death (Jem 23a) (Type, Print) ranklin Square Dr, Baltimore, MI)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day

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ar's Signature

32. Pe

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death Month Day 14:50 FEBRUARY 24, 2008 4b. City, Town, or Location of Death 4c. County of Death BEL AIR HARFORD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Days 1**X** M 2□ F Months Hours Min. 84 July 14, 1923 Maryland 10c. City, Town or Location 10b. County Bel Air 10f. Zip Code 10g. Citizen of What Country? 21014 USA 14. Race - American Indian,

1 - State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** EDWARD FRANCIS KAMINSKI SR. /Medical 4a. Facility Name (If not institution, give street and number) Examiner UPPER CHESAPEAKE MEDICAL CENTER Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 215-14-9801 Director Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Harford 10e. Street and Number 801 W. Farrow Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2004 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Frieda Rosalie Seaderer John Frank Kaminski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Violet Kaminski / Wife 801 W. Farrow Court, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans 2-29-08 Owings Mills, MD McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MASSIVE UPPER GASTROINTESTINAL BLEED Immediate Cause (Final Physician 2 hours disease or condition resulting in death) /Medical we to (or as a consequence of): **Examiner** MULEATIC 3mm the Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death 9☐Unknown Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

UPER Chesapeake Medical Center Bel AR MD

relea gun, mo 30. Nam, and address of person who completed cause if death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

AFTERNAL

FEBRUARY 24, 2008

|                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   | 1 - For<br>State<br>Registrar                                                                                                                                                                                                                                                                    | State of Maryland                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | rtment of F                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ental Hygie                                    | 6.000                                    | 06276                                                       |
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| 0                                       | Physici<br>/Medic<br>Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | al                | Decedent's Name (First, Middle,     Lucy Edna Kei     4a. Facility Name (If not institution,                                                                                                                                                                                                     | thley<br>give street and number)                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4b. City, Town                          | 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 2. Date of Death<br>Month                      | Day Year 25 2008 4c. County of Dea       | 3. Time of Death  345 p M                                   |
|                                         | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   | 218-46-3524                                                                                                                                                                                                                                                                                      | KWINSIDL<br>5. Sex 7. Age (In yrs. Ia<br>1 M 25D F 98                                          | st birthday)<br>Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | If Under 1 Year<br>Months Days          | Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | B. Date of Birth (Month, Day, Y                | 9. Bir<br>1909 Mar                       | thplace (State or Foreign suntry)  yland                    |
|                                         | 72 hours after death with the Maryland<br>natural; or Items 23e or 28a-f show<br>lical Examinat must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ector             | Usual Residence of Decedent 10a. State 10b. County  Maryland Harfore                                                                                                                                                                                                                             |                                                                                                | Town or Loc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ,                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                |                                          | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No                      |
|                                         | death with the ms 23e or 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Funeral Directo   | 10e. Street and Number  1412 Philadelpl  11. Marital Status                                                                                                                                                                                                                                      | 12. Was Decedent Ever in U.S                                                                   | i. 13. W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10f. Zip Code 21085  /as Decedent of H  | lispanic Origin? (Spec<br>an, Mexican, Puerto R                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | US                                             | Citizen of What Co                       |                                                             |
| 9800                                    | hours after<br>tural, or Ite                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | þ                 | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                                                                                                                                                                                                                                           | If Yes, Give Year or Dates:                                                                    | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | □Yes 2录No                               | Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                | <del></del>                              | Mhite                                                       |
| / <i>  ≤ / / /</i><br>21215-0036        | d within 72<br>giene.<br>er then "net                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Completed         | 15. Decedent's (Specify only highest Elementary/Secondary (0-12)                                                                                                                                                                                                                                 | Education<br>grade completed)  College (1-4or 5+)                                              | (Give k                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | O NOT use retired                       | during most of working                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                | b. Kind of Business<br>Iwn Home          | /Industry                                                   |
| Maryland                                | hould be filed<br>d Mental Hygi<br>narked other<br>natic event, ii                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | To Be             | 17. Father's Name (First, Middle, La<br>Charles Edward                                                                                                                                                                                                                                           | Simms                                                                                          | 101. 14. 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | First, Middle, Ma.<br>a (nmn)                  | iden Sumame)<br>Chenowith                |                                                             |
|                                         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Items 23a or 28a-f show eny injury or other traumatic event, Ita Medical Examinar must be notified at once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   | 20a. Method of Disposition                                                                                                                                                                                                                                                                       | nins / Daughter                                                                                | 203 Da                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         | : Da                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | re de Gr                                       |                                          | 21078                                                       |
| レロヘ/<br>Baltimore,                      | permit. Pagi<br>Department<br>Importent: If<br>eny injury o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                   | 1X Buria 2 ☐ Cremation 3<br>4 ☐ Denation 5 ☐ Other (Spe<br>21. Sign ture of Funers (Service Lice                                                                                                                                                                                                 | city) Bel                                                                                      | Air Me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | emorial occomas Fi                      | Grdn 3-2-0<br>ss of Facility<br>Uneral Hom                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | e, P.A.                                        | el Air, Ma                               |                                                             |
| 760,                                    | Physician /Medical Examiner price and price price and price price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in the price in t | I Examiner        | 23a. Part . Enter the disease, or consock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last | Α Α                                                                                            | Do not enter  Practice of):  Methodological procession of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont | the mode of dyin                        | sbury Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | respiratory arrest                             |                                          | and 21009 Approximate Interval Between Onset and Death Week |
| Division of Vital Records, P.O. Box 687 | law requires that the death certificate as been signed by the attending physical should be detached for use as the terms.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ Mo 9 □ Unknown                                                                                                                                                                                                          | d                                                                                              | leath 3 □E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Ectopic pregnancy<br>Other (specify)    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                | 23d. Date of del<br>Month                | ivery<br>Day Year                                           |
| ırds, P.                                | w requires that the been signed by should be detaction                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | þ                 | Part II. Other significant conditions                                                                                                                                                                                                                                                            | contributing to death but not result                                                           | ing in the und                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | derlying cause give                     | en in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                |                                          | othe cause of death?                                        |
| al Reco                                 | ysicien: The law rass certificete has be director, page 2 shr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Completed         | V                                                                                                                                                                                                                                                                                                |                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 24a. Was an<br>autopsy<br>performed<br>1 Yes 2 | death?                                   | Itopsy findings available completion of cause of            |
| of Vit                                  | Physician<br>this certif<br>ral director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | To Be             | 25. Was case referred to medical examiner?  1 ☐ Yes 21 No                                                                                                                                                                                                                                        | Hospital: 1   Inpatient 2   El                                                                 | R/Outpatient                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 3□ DOA Oth                              | 26. Place of Death of Place of Death of Place of Death of Place of Death of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of |                                                | e 6 ⊡Other (Spe                          | city)                                                       |
| ion                                     | Attending Physicien: The rideath. setor: Alter this certificate hiby the funeral director, page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | atlon:            | 27. Manner of Death  1. Natural 5 ☐ Pending 2 ☐ Accident investigat                                                                                                                                                                                                                              | (Month, Day Year)<br>ion                                                                       | 8b. Time of<br>Injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 28c. Injun<br>Work                      | y at 28<br>k?<br>Yes 2 □ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | d. Describe how                                | injury occurred                          |                                                             |
| Divis                                   | 9 # # -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Certification:    | 3 ☐ Suicide 6 ☐ Could not determine                                                                                                                                                                                                                                                              |                                                                                                | e, farm, stree                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | et, factory, office                     | 28                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | f. Location (Stree<br>City or Town, S          | t and Number or Ruitate)                 | ıral Route Number,                                          |
| (5)                                     | Hosp<br>24 hou<br>Funer<br>fely fill                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Medical           | 29a. Certifier 1 ☐ Certifying I (Check only one)                                                                                                                                                                                                                                                 | Physician: To the best of my knowl<br>aminer: On the basis of examinatio<br>and manner stated. | edge, death on and/or inve                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | occurred at the timestigation, in my op | ne, date and place, an<br>pinion, death occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | d due to the caus<br>at the time, date         | e(s) and manner as<br>and place, and due | stated.<br>to the cause(s)                                  |
| •                                       | To the within 2 To the comple                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Ž                 | 29b. Signature and title of certifier                                                                                                                                                                                                                                                            | u mo                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 29c. License                            | e number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 29d.                                           | Date signed (Monta                       | h, Day, Year)                                               |
| 5                                       | 6 Y                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   | Name and address of person wh                                                                                                                                                                                                                                                                    | o completed cause of death (Item 2 MILL our PLA)  008  Registrar's Signature                   | 3a) (Type, P                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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|                                         | Stat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | е                 | 31. Date filed (Month Day Year) 2                                                                                                                                                                                                                                                                | 108 32 Registrar's Signatur                                                                    | (B)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                |                                          |                                                             |

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Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 FEBRUARY 27 8:57 A M **FOSTER** A LEWIS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE JOHNS HOPKINS-BAYVIEW 8. Date of Birth (Month, Day, Year) 09-01-1932 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min 1 XM 2 □ F 213-36-7206 75 Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ¥Yes 2 □ No Director **EDGEMERE** MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7409 LINWOOD AVENUE 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. and Team 27 Is marked other than "natural", or ite XYes 2 No Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 ☐ Divorced BLACK Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STEEL STEEL WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARTHA JANE PATTERSON MACE R. LEWIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tra once. 7409 LINWOOD AVE. EDGEMERE, MARYLAND 21219 IRIS R. LEWIS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-5-2008 CROWNSVILLE, MARYLAND CROWNSVILLE VET.CEM. 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. ure of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 23a. Pan Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should b Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** myocardial interction acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CAM. 17 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 22 No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Funeral Tacertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)0055157 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALANSON Rd. SHARON Point For + North 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

State Registrar Christopher

31. Date filed (Month, Day, Year)

Greene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

Marluci

South

Begistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 18:15PM John Law February 25 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Harbor Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Days 1⊠M 2∏ F 53 Dec. 14,1954 Maryland Director 213-68-5720 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Halethorpe Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 21227 USA 2750 Norfen Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 □ Divorced "natural"; Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 Is marked other the any injury or other traumatic event, the once. 12 Cemetery Sexton 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John H. Law, Sr. Doris Osborn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2750 Norfen Road; Halethorpe, Maryland 21227 Ray Gilliss III Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 2/29/2008 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. MD 21228 1630 Edmondson Avenue: Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreatic **Physician** Cancer /Medical Due to (or as a consequence of) Examiner Pramonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director; After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the hirial Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐ Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Unpatient Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

To the Hospital within 24 hours a To the Funeral C

State Registrar

Sairah Bashir 31. Date filed (Month, Day, Year)

29b. Signature and title of cegtifier

29a. Certifier

Medical



and manner stated.

Doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 South Hanover street Baltimore, Maryland 21225

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Resool

29d. Date signed (Month, Day, Year)

February 25, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ELIZABETH LONGEN ECHEN **Physician** 2.55 A M -eB 28, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BATTIMORE GILCHRIST CENTRI 10W300 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗷 F 95 Yrs. 578-26-6975 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov notified at 1 ☐ Yes 2 No BEL HARFORD Be Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be 45.4 SHAWNEE 21019 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Witte 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETAR DEPARTMENT STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KOBERT EDWARDS SCOTT 2 19a. Informant's Name/Relationship (Type. Print) D445 # T CS5 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 SHAWNEE LANE HARTETT 20a. Method of Disposition 120 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any Injury or ot ₩ Burial 2 Cremation 3 Removal from State 4/08 LINCOLN Cem, BREVTWOOD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility FLETCHER Function MAIN ST. WESTMUSTER, MD 254 E 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ure **Physician** Wear resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trai Due to (or as a consequence of) attending physician for use as the buria Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 Other (specify) ed by the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 | No 3 | Probably 4 | Unknown Be Completed ease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform rmed2 2∐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Division or Vital Records, P.O. Box 68760 To the

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Fe Grunny 28, 2008 297 , und

V. Charles (+.

Balto. M

State Registrar

39. Registrar's Signature 31. Date filed (Month, Day, Year) 2008 FEB 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

|                   |                                                                                                                                                                                    |                   | 1 - For<br>Stete<br>Registrar                                                                               | State o                | f Maryland /                               | •                 | artment of F<br><i>rtificate of</i>                          |                           |                                    |                               | ene () () 8                                 | 062                                   | 81                   |
|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------|------------------------|--------------------------------------------|-------------------|--------------------------------------------------------------|---------------------------|------------------------------------|-------------------------------|---------------------------------------------|---------------------------------------|----------------------|
|                   | 5                                                                                                                                                                                  | )                 | 1. Decedent's Name (First, Middle, La                                                                       | ast)                   |                                            |                   | ***************************************                      |                           |                                    | Date of Death                 | 1                                           | 3. Time of                            | Death                |
|                   | Physic                                                                                                                                                                             |                   | Dorothy G. I                                                                                                | ankford                |                                            |                   |                                                              |                           |                                    | Month<br>bruary               | 25, 2008                                    | 12:55                                 | $P^{M}$              |
|                   | /Medi<br>Examir                                                                                                                                                                    |                   | 4a. Facility Name (If not institution, gi                                                                   | ve street and nui      | mber)                                      |                   | 4b. City, Town, o                                            | r Location                |                                    |                               | 4c. County of Dea                           |                                       |                      |
|                   |                                                                                                                                                                                    |                   | Wilson Healthcar                                                                                            | e Cente                | r                                          |                   | Gaithers                                                     | ourg                      |                                    |                               | Montgom                                     | ery                                   |                      |
| 1                 | Funeral                                                                                                                                                                            |                   |                                                                                                             | Sex                    | 7. Age (In yrs. last                       | birthday,         | If Under 1 Year<br>Months Days                               |                           | r 24 Hrs. 8.                       | Date of Birth<br>(Month, Day, | 9. Bir                                      | thplace (State or                     | or Foreign           |
| 38                | Director                                                                                                                                                                           |                   | 443-22-5671                                                                                                 | 1 □ M 2 💢 F            | 98                                         | Yrs.              | Months Days                                                  | Hours                     |                                    |                               | 3, 1909 New                                 | York                                  |                      |
|                   | <b>D</b> .                                                                                                                                                                         |                   | Usual Residence of Decedent                                                                                 |                        |                                            |                   |                                                              |                           |                                    |                               |                                             |                                       |                      |
|                   | inylar<br>ohow                                                                                                                                                                     |                   | 10a. State 10b. County                                                                                      |                        | 10c. City, To                              | own or L          | ocation                                                      |                           |                                    |                               |                                             | 10d. Inside Cit                       |                      |
|                   | h the Maryland<br>r 28a-f ehow<br>incititied at                                                                                                                                    | cto               | Maryland Montgome                                                                                           | ry                     | Gaith                                      | ersb              |                                                              |                           |                                    |                               |                                             | 1 X Yes                               | 2   NO               |
|                   | or 20                                                                                                                                                                              | Director          | 10e. Street and Number                                                                                      |                        |                                            |                   | 10f. Zip Code                                                |                           |                                    | 10                            | g. Citizen of What Co                       | ountry?                               |                      |
|                   | 72 hours after death with the Maryland<br>natural', or items 23a or 28a-f ehow<br>dical Examinet must be notified at                                                               | Funeral I         | 333 Russell Aver                                                                                            | ue, #52                | 1                                          |                   | 20877                                                        |                           |                                    | U1                            | nited Stat                                  |                                       |                      |
|                   | Items                                                                                                                                                                              | Ine               | 11, Marital Status                                                                                          | Armed Fo               |                                            | 13.               | Was Decedent of H<br>If Yes, specify Cubi                    | lispanic Oi<br>an, Mexica | rigin? (Specify<br>an, Puerto Rica | Yes or No-<br>in, etc.)       | 14. Race - Ame<br>Black, Whit               |                                       |                      |
| 36                | or It                                                                                                                                                                              | by Fu             | 1 Never Married 2 Married                                                                                   | 1 ☐ Yes<br>If Yes, Gir | <b>/</b> 8                                 |                   | 1 ☐ Yes 2 ☑ No                                               | Specify                   | <i>/</i> :                         |                               | Specify:                                    |                                       |                      |
| 21215-0036        | 72 hours<br>"natural",<br>oleal Exe                                                                                                                                                |                   | 3 ☑ Widowed 4 ☐ Divorced                                                                                    | Year or D              |                                            |                   |                                                              |                           |                                    |                               | WI                                          | nite                                  |                      |
| 5                 | - 2                                                                                                                                                                                | Completed         | 15. Decedent's E<br>(Specify only highest gi                                                                |                        |                                            | 6a. Dece<br>(Give | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | ation<br>during mo        | st of working                      | 1                             | 6b. Kind of Business                        |                                       | <b></b> -            |
| 12                | within<br>ene.<br>then "                                                                                                                                                           | E D               | Elementary/Secondary (0-12)                                                                                 | College (              |                                            |                   | eacher                                                       | 4)                        |                                    |                               | Montgomer<br>Public Sc                      | 2                                     | Ly                   |
| 22                | filed<br>Hygir<br>ther                                                                                                                                                             | e Co              | 17. Father's Name (First, Middle, Las                                                                       |                        |                                            |                   | eacher                                                       | 18. Moth                  | ner's Name (Fi                     | rst Middle N                  | laiden Sumame)                              | 110012                                |                      |
| an                | ould be<br>Mental<br>Marked o                                                                                                                                                      | 00                | Chester Morgan                                                                                              | Greene                 |                                            |                   |                                                              |                           | n Eliza                            |                               |                                             |                                       |                      |
| Maryland          | 2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, It e M.                                                                                           | ၉                 | 19a. Informant's Name/Relationship                                                                          |                        | 1                                          | 9h Maili          | ng Address (Street                                           |                           |                                    |                               | City or Town, State,                        | Zin Code)                             |                      |
| <u>s</u>          | id 2 s<br>th ar<br>27 ls<br>trau                                                                                                                                                   |                   | Jon R. Lankf                                                                                                |                        |                                            |                   | thayres (                                                    |                           |                                    |                               |                                             | 0855                                  |                      |
|                   | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other then any injury or other traumatic evant, ILE M. QDGE. |                   | 20a. Method of Disposition                                                                                  | oru                    | 20b. Place                                 | of Dispo          | osition (Name of                                             |                           |                                    |                               | Oc. Location - City or                      |                                       |                      |
| 0                 |                                                                                                                                                                                    |                   | 1 ⊠Burial 2 ☐ Cremation 3 [                                                                                 |                        | State                                      |                   | matory or other pla                                          | · 1                       | ebruar                             | y 29,                         |                                             |                                       | اد م                 |
| Baltimore,        |                                                                                                                                                                                    |                   | 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice                                           |                        | Parkla                                     |                   | <b>norial Park</b><br>2. Name and Addre                      | -                         | 2008                               | K                             | ockville,                                   | Marylar                               | .10                  |
| Ba                | Depa<br>Impo<br>any ii                                                                                                                                                             |                   | Santa h                                                                                                     | Xow 7                  | M01193                                     | Ro<br>30          | bert A. I<br>O W. Montgo                                     | Pumph<br>nery Av          | rey Fur<br>venue, Ro               | neral E<br>ckville            | Home/Rockv<br>Maryland 20                   | ille, I                               | nc.                  |
|                   |                                                                                                                                                                                    |                   | 23a. Part1. Enter the disease, or con<br>shock, or heart failure. List only                                 | plications that of     | aused the death. Deach line.               | o not en          | ter the mode of dyir                                         | ng, such as               | s cardiac or re                    | spiratory arre                | st,                                         | Approximate<br>Interval Bety          | ween                 |
|                   | Physician                                                                                                                                                                          |                   | Immediate Cause (Final disease or condition                                                                 | Acut                   | e Myocard                                  | ial               | Infarctio                                                    | on                        |                                    |                               |                                             | Onset and D                           |                      |
|                   | /Medical                                                                                                                                                                           |                   | Due to (or as a consequence of):                                                                            |                        |                                            |                   |                                                              |                           |                                    |                               |                                             |                                       |                      |
| . Asia            | Examiner                                                                                                                                                                           |                   | Sequentially list conditions.                                                                               | isease                 |                                            |                   |                                                              |                           |                                    |                               |                                             |                                       |                      |
| 7                 | pd ji                                                                                                                                                                              | ine.              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to                 | (or as a consequent                        | ce of):           |                                                              |                           |                                    |                               |                                             |                                       |                      |
| V                 | and<br>-tran                                                                                                                                                                       | Examiner          | that initiated events resulting in death) Last                                                              | c. Demen               | ntia<br>(or as a consequenc                |                   |                                                              |                           |                                    |                               |                                             |                                       |                      |
| 60,               | be executed<br>ician and<br>burial-transit                                                                                                                                         | Ê                 |                                                                                                             | Due to                 | (or as a consequent                        | ce or):           |                                                              |                           |                                    |                               |                                             |                                       |                      |
| 8760,             | ate<br>phys<br>the                                                                                                                                                                 | dical             | •                                                                                                           | _d                     |                                            |                   |                                                              |                           |                                    |                               |                                             |                                       |                      |
| 9                 |                                                                                                                                                                                    | 0                 | IF FEMALE:                                                                                                  | 220 If you out         | come of pregnancy                          |                   |                                                              |                           |                                    |                               |                                             |                                       |                      |
| Вох               | death certifi<br>e attending<br>d for use as                                                                                                                                       | Physician/M       | 23b. Was decedent pregnant in the past 12 months?                                                           | 1 Live b               | irth 2 Fetal dea                           | ath 3[            | Ectopic pregnancy                                            | /                         |                                    |                               | 23d. Date of de<br>Month                    |                                       | Year                 |
|                   | the de                                                                                                                                                                             | ysic              | 1 ☐ Yes 2 ဩNo<br>9 ☐ Unknown                                                                                | 4∐ Pregn<br>9□ Unkn    | ant at time of death<br>own                | 1 5               | Other (specify)                                              |                           |                                    |                               |                                             |                                       |                      |
| P.0.              | requires that the<br>een signed by th<br>nould be detache                                                                                                                          | P                 | Part II. Other significant conditions                                                                       | contributing to di     | eath but not resulting                     | a in the L        | Inderlying cause giv                                         | en in Part                |                                    | 23e. Did tob                  | acco use contribute le                      | o the cause of di                     | leath?               |
| ds,               | Se C 90                                                                                                                                                                            | 1 by              | Hypertention, And                                                                                           |                        |                                            |                   |                                                              |                           | 1                                  |                               | s 2 No 3 P                                  |                                       |                      |
| Ö                 |                                                                                                                                                                                    | etec              |                                                                                                             |                        |                                            |                   |                                                              |                           |                                    |                               |                                             |                                       |                      |
| of Vital Records, | g 85 C                                                                                                                                                                             | Completed         | Breast Carcinoma,                                                                                           | Recurr                 | ent Urina                                  | ry 1              | ract inie                                                    | SCLIO                     | <u>n</u>                           | 24a. Was an autopsy           | prior to                                    | utopsy findings a<br>completion of ca | available<br>ause of |
| 100               | ate pag                                                                                                                                                                            |                   |                                                                                                             |                        |                                            |                   |                                                              |                           |                                    | perform<br>1 ☐ Yes 2          | No 1 ☐ Yes                                  | 2 □ No                                |                      |
| VIE<br>VIE        | Physician: The this certificate ral director, pag                                                                                                                                  | Be                | 25. Was case referred to medical examiner?                                                                  | Hospital:              |                                            |                   | 1.0#                                                         |                           | e of Death (Ci                     | heck only one                 | )                                           |                                       |                      |
| of                | ding Phys<br>h.<br>After this<br>funeral dir                                                                                                                                       | ၉                 | 1 Yes 2 X No 27. Manner of Death                                                                            | 101                    | Inpatient 2 ER/                            |                   |                                                              | + 177 14                  | -                                  |                               | nce 6 Other (Spe                            | icity)                                |                      |
|                   | S 9 9                                                                                                                                                                              | <u>0</u>          | 1 XNatural 5 ☐ Pending                                                                                      |                        | th, Day Year)                              | b. Time o         | Wor                                                          |                           |                                    | Describe no                   | w injury occurred                           |                                       |                      |
| Sic               | Attending in death.                                                                                                                                                                | cat               | 2 Accident investigated 3 Suicide 6 Could not I                                                             | 20                     | of laines At home                          |                   |                                                              | Yes 2                     |                                    | Lanation /Str                 | ant and Alumbar as D                        | usel Deute Muse                       |                      |
| Division          | or A<br>after<br>Direction by                                                                                                                                                      | Certification: To | 4 Homicide determined                                                                                       | 289. Place             | of Injury - At home,<br>ng, etc. (Specify) | , rarm, st        | reet, factory, office                                        |                           | 201.                               | City or Town,                 | eet and Number or R<br>State)               | urai Houte Numi                       | Der,                 |
|                   | pital<br>burs a<br>erat<br>filled                                                                                                                                                  |                   | 29a. Certifier 1⊠ Certifying P                                                                              | hyeinianı To the       | bast of my knowles                         | dan dan           | (b. a                                                        |                           |                                    | dua to the se                 |                                             |                                       |                      |
|                   | 24 ho<br>Fun                                                                                                                                                                       | Medical           |                                                                                                             | miner: On the b        | asis of examination<br>ner stated.         | and/cr in         | restigation, in my o                                         | pinion, de                | ath occurred a                     | it the time, da               | use(s) and manner a<br>te and place, and du | s stated.<br>e to the cause(s)        | )                    |
|                   | To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fur                                                               | Me                | 29b. Signature and title of certifier                                                                       | and man                | outdu                                      |                   | 29c. Licens                                                  | e number                  | -                                  | 29                            | d. Date signed (Mon                         | th, Day, Year)                        |                      |
|                   | ⊢ 3 <del>-</del> 8                                                                                                                                                                 |                   | > 4. Riher                                                                                                  | +. Risa                | whi                                        | -12               |                                                              |                           |                                    |                               | -                                           |                                       |                      |
|                   | 1.1                                                                                                                                                                                |                   |                                                                                                             |                        |                                            | -                 | 0 201                                                        | 112                       |                                    | F                             | 'ebruary 2                                  | o, 2008                               |                      |
|                   | 11                                                                                                                                                                                 |                   | 30. Name and address of person who<br>H. Robert Birschba                                                    |                        |                                            |                   | •                                                            | there                     | huro 1                             | Marula                        | nd 20877                                    |                                       |                      |
| 1000              | Sta                                                                                                                                                                                | to.               | 31. Date filed (Month, Day, Year)                                                                           |                        | legistrar's Signature                      |                   | muc, Gal                                                     | CHET 2                    | burg, I                            | тагута                        | 200//                                       |                                       |                      |
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| cate be executed | physician and<br>the burial-transit |

Division or Vital Records, P.O. Box 68760,

| - 57                                                       | 1 - State Registrar                                                                                                                                                                                                                                                                                                                                                                                                                        | (ant)                                                                                                                                                                                                                      |                                                                                                                           | Certificate                                                                                                                                                         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DO NOT use                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Occupation done during                                                                        | most of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ring                                                                                                                  | 16b. 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| e completed by Physician/Medical                           | Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes                                                                                                                                                                                                                                                                       | Due to (or as a  c.  Due to (or as a  d.  23c. If yes, outcome p  1 Live birth 2  4 Pregnant at ti 9 Unknown  s contributing to death but                                                                                  | f pregnancy Fetal death rine of death                                                                                     | of):  3 □Ectopic pre 5 □ Other (spe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | use given in F                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1 24a. 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| to be completed by Physician/Medical                       | Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No                                                                                                                                                                                  | Due to (or as a c                                                                                                                                                                                                          | f pregnancy Fetal death rime of death not resulting in                                                                    | of):  3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | use given in F                                                                                | Place of Deat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 24a. 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Manner of Death 1 Natural 5 Pending                                                                                                                | Due to (or as a c                                                                                                                                                                                                          | f pregnancy Fetal death for resulting it                                                                                  | of):  3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | use given in F                                                                                | Place of Deat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 24a. 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F  Other: 4  Work? 1 □ Yes                                                                | Place of Deat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 24a. 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Describe                                                      | tobacco use c  Yes 2 No s an opsy formed? 2 No one) sidence 6 No (Street and No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1225 Day Month Veal 2008 28 CHAEL 4b. City, Town, or Cocation of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Seasons Hospice Randallstown Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months 1**∑** M 2□ F Yrs 79 July 14,1928 MD 212-26-5260 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☑ No MD Pikesville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7432 Rockridge Road 21208 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2X Married 2**∑** No 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner 12 Auto Parts 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Joseph McCarthy, Sr. Ester Porter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances McCarthy Wife 7432 Rockridge Road, Pikesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 3/1/08 4 Donation 5 Other (Specify) Pikesville, MD 21. Signature of Funeral Solvice Licensee 22. Name and Address of Facility 11824 Reisterstown Road 86 Eline Funeral Home Reisterstown, MD 21136 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final vos tak disease or condition resulting in death) to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. End Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 22 No death? 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 1 Yes 2 No

Physician /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

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Director

Funeral

Completed by

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permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Health tem 27

Important: If It any injury or o

Baltimore, Maryland 21215-0036

/Medical

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Division or Vital Records, P.O. Box 68760,

Examine Certifica

| nysician/Medica           | IF FEMALE:<br>23b. Was decedent<br>in the past 12 n<br>1 □ Yes 2 □<br>9 □ Unknown |
|---------------------------|-----------------------------------------------------------------------------------|
| Completed by Physician/Me | Part II. Other signific                                                           |
| ion: To Be Con            | 25. Was case referred examiner? 1 Yes 250 27. Manner of Death                     |

2 Accident

29b. Signature and title of certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the

State Registrar

Medical

6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier (Check only one)

28a. Date of Injury (Month, Day Year) 5 Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who npleted cause of death (Item 23a) (Type, Print)

25 MA15 ree K 32 31. Date filed (Month, Day, Year)

Kens Istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛛 🖺 🦯 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 450 M **Physician** ROBERT MONTGOMERY FEBRUARY ZIZOOS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BON SECOURS HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1**X** M 2□ F Republic of lanama 214-64-0081 52 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene. importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 1 Yes 2 □ No Baltimore MD Director NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Koad 21207 3232 Kelox Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) League College (1-4or 5+) Elementary/Secondary (0-12) Carequer Hand cappe 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dora Eddie Montgomery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Prin 👡 🖵 a twee Apostle Eddie A. Montgoment Drive 3429 Dayta MO Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Baltimore, MD Woodlawn Cenetery 8/08 22. Name and Address Facility
Joseph h Poss
222 W North 21. Signature Funeral Service Licenses Funeral Home, RA Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

→ Ses 2 □ No 24a. Was an 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this medition 26. Place of Death Ch ck onl one 25. Was case referred to medical examiner? Be Hospital: ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Yes 2 No 28a. Vate of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28h. Time of Certification; Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 24100 AIR 440 BEC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LADURA ABHAKAR 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 2008 Registrar

|                   |                                                                                                                                                                                                                                                                                                      |                     | For S                                                                                                | tate of Maryland                                                                   | / Department of Health an                                                                         | d Mental Hygie                                                          | ne nno ncos                                                          |
|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------|
|                   |                                                                                                                                                                                                                                                                                                      |                     | For State Registrar                                                                                  |                                                                                    | Certificate of Death                                                                              | Reg.                                                                    | 2000 00200                                                           |
|                   | Physici                                                                                                                                                                                                                                                                                              | an                  | 1. Decedent's Name (First, Middle, Last)                                                             | T. fosla                                                                           |                                                                                                   | 2. Date of Death Month                                                  | Day Year 4:05pm                                                      |
|                   | /Medio<br>Examir                                                                                                                                                                                                                                                                                     |                     | 4a. Facility Name (If not institution, give stre                                                     | et and number)                                                                     | 4b. Cilyn Town, or Location of D                                                                  |                                                                         | 4c. County of Peath                                                  |
|                   |                                                                                                                                                                                                                                                                                                      |                     | 500d Sama                                                                                            | Ritan Hos                                                                          | nital Balti                                                                                       | WRE                                                                     | NA                                                                   |
|                   | Funeral<br>Director                                                                                                                                                                                                                                                                                  |                     | 5. Social Security Number 6. Sex                                                                     | 2 F 7. Age (In yrs. las                                                            | s birthday) If Under 1 Year If Under 24 Months Days Hours M                                       | Hrs. 8. Date of Birth<br>Min. Month, Day, Ye                            | ar) 9. Birthplace (State or Foreign                                  |
|                   | D                                                                                                                                                                                                                                                                                                    | ·                   | Usual Residence of Decedent  10a. State 10b. County                                                  | 10c City                                                                           | Town or Location                                                                                  | Barri 19,1                                                              | 10d. Inside City Limits                                              |
|                   | filed within 72 hours after death with the Maryland<br>Hygiene.<br>other than "neturel", or Items 23e or 28e-f show<br>ent, the Medical Exertains or must be codified at                                                                                                                             | tōr                 | Md. NA                                                                                               | P                                                                                  | Baltimore                                                                                         |                                                                         | 1 Yes 2 □ No                                                         |
|                   | or 289                                                                                                                                                                                                                                                                                               | by Funeral Director | 10e. Street and Number                                                                               | 1 41                                                                               | 10f. Zip Code                                                                                     | 10g.                                                                    | Citizen of What Country?                                             |
|                   | eath w                                                                                                                                                                                                                                                                                               | eral                | 3232 Barc  11. Marital Status 12.                                                                    | Was Decedent Ever in U.S.                                                          | 2/2/8                                                                                             | (Specify Yes or No-                                                     | 14. Race - American Indian,                                          |
| ထွ                | or Iten                                                                                                                                                                                                                                                                                              | Fun                 | 1 Never Married 2 Married                                                                            | Armed Forces?<br>1 □ Yes 2 1 No<br>If Yes, Give                                    | . 13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P  1 □ Yes 2 ☑ No Specify: | uerto Rican, etc.)                                                      | Black, White, etc.  Specify: 771                                     |
| 215-0036          | hours<br>turel',                                                                                                                                                                                                                                                                                     | ed by               | 3 Widowed 4 □ Divorced  15. Decedent's Educati                                                       | Year or Dates:                                                                     | 16a. Decedent's Usual Occupation                                                                  | 16b                                                                     | Black<br>Kind of Business/Industry                                   |
| 215               | hin 72<br>e.<br>an "ne<br>Medic                                                                                                                                                                                                                                                                      | Completed           | (Specify only highest grade co                                                                       | College (1-4or 5+)                                                                 | (Give kind of work done during most of life. DO NOT use retired)                                  | working                                                                 | A / 1 · /                                                            |
| 7                 | filed with<br>Hygiene.<br>Sther tha                                                                                                                                                                                                                                                                  | S                   | 17. Father's Name (First, Middle, Last)                                                              | 0                                                                                  | Mechanic                                                                                          | Name (First, Middle, Maid                                               | 4utomobile                                                           |
| Maryland          | buld be f<br>Mental P<br>arked of<br>atic eve                                                                                                                                                                                                                                                        | To Be               | Frank For                                                                                            | tune                                                                               | Sal                                                                                               | W Mc.T                                                                  | ntosh                                                                |
| lary              | 2 should<br>and Men<br>is marke<br>raumatic                                                                                                                                                                                                                                                          |                     | 19a, Informant's Name/Relationship (Type,                                                            | 7 1 9 7                                                                            | 19b. Mailing Address (Street and Number of                                                        | r Rural Route Number, Cit                                               | ty or Town, State, Zip Code)                                         |
|                   | 1 and<br>Health<br>tem 27<br>other tr                                                                                                                                                                                                                                                                |                     | 20a. Method of Disposition                                                                           | Peter Kin                                                                          | ce of Disposition (Name of                                                                        | Date 20c                                                                | Location - City or Town, State                                       |
| altimore,         | Pages<br>nent of I<br>ant: If its<br>ary or o                                                                                                                                                                                                                                                        |                     | 1 X Burial 2 ☐ Cremation 3 ☐ Rem<br>• 4 ☐ Donation 5 ☐ Other (Specify)                               | oval from State                                                                    | Himore Cemetery 3                                                                                 | 3/2008 E                                                                | saito Md.                                                            |
| Balt              | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23e or 28a-1 show enty injury or other traumatic event, the Madical Exertal national be notified at once. |                     | 21. Signature of Funeral Service Licensee                                                            | & Rus                                                                              | Name and Address of Facility JOSEPH L. RUSS                                                       | Funeral He                                                              | ome, P.A.                                                            |
|                   | 45204                                                                                                                                                                                                                                                                                                |                     | 23a. Part / Enter the dispase, or complicati                                                         | ons that caused the death.                                                         | Do not enter the mode of dying, such as car                                                       | Ave. Bull diac or respiratory arrest,                                   | to, Md. 21216<br>Approximate                                         |
|                   | Physician                                                                                                                                                                                                                                                                                            |                     | shock or hear failure. List only one c<br>Immediate Cause (Final<br>disease or condition             | ause on each line.                                                                 |                                                                                                   |                                                                         | Interval Between<br>Onset and Death                                  |
|                   | /Medical<br>Examiner                                                                                                                                                                                                                                                                                 |                     | resulting in death)                                                                                  | Due v (or as reon eque                                                             | Rean Failes                                                                                       | 0.0                                                                     |                                                                      |
|                   |                                                                                                                                                                                                                                                                                                      | Jer                 | Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying                 | Due to (or as a goneeque                                                           | model):                                                                                           | 4                                                                       |                                                                      |
|                   | ecuted<br>and<br>I-transi                                                                                                                                                                                                                                                                            | Examiner            | Cause (Disease or injury that initiated events resulting in death) Last                              | Due to (or as a conseque                                                           | my opathy                                                                                         |                                                                         |                                                                      |
| 760,              | death certificate be executed e attending physicien and vd for use as the burial-transit                                                                                                                                                                                                             | ical E              | d                                                                                                    | 200 10 (0) 00 0 00130000                                                           |                                                                                                   |                                                                         |                                                                      |
| 89                | artificat<br>ing phy<br>e as th                                                                                                                                                                                                                                                                      | Medi                | IF FEMALE:                                                                                           |                                                                                    |                                                                                                   |                                                                         |                                                                      |
| . Box             | leath certifica<br>attending phy<br>I for use as th                                                                                                                                                                                                                                                  | cian/               | 23b. Was decedent pregnant in the past 12 months?                                                    | If yes, outcome of pregnand<br>1□Live birth 2□Fetal d<br>4□Pregnant at time of dea | leath 3 □Ectopic pregnancy                                                                        |                                                                         | 23d. Date of delivery<br>Month Day Year                              |
| <u>о</u> .        | that the de<br>led by the a<br>detached t                                                                                                                                                                                                                                                            | Physician/Med       | 9 Unknown                                                                                            | 9□Unknown                                                                          |                                                                                                   |                                                                         |                                                                      |
|                   | Physicien: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.                                                                                                                                                                               | þ                   | Part II. Other significant conditions contrib                                                        | uting to death but not resulti                                                     | ing in the underlying cause given in Part I.                                                      | 23e. Did tobacc                                                         | 2 No 3 Probably 4 Chrknown                                           |
| Records,          | s been<br>shoul                                                                                                                                                                                                                                                                                      | Completed           |                                                                                                      |                                                                                    |                                                                                                   | 24a. Was an                                                             | 24b. Were autopsy findings available prior to completion of cause of |
|                   | ding Physicien: The lav<br>h.<br>After this certificate has<br>funeral director, page 2                                                                                                                                                                                                              | Com                 |                                                                                                      |                                                                                    |                                                                                                   | — autopsy performed 1 ☐ Yes 2 ☑                                         | ?death?                                                              |
| V Ita             | sicien:<br>certific<br>irector,                                                                                                                                                                                                                                                                      | o Be                | 25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{Vo} \) | pital:                                                                             |                                                                                                   | Death <i>(Check only one)</i> g Home 5 \( \subseteq \text{Residence} \) | 0 □00 × (0 × (1)                                                     |
| اه ر              | ng Phy<br>ter this<br>neral d                                                                                                                                                                                                                                                                        | J                   | 27. Manner of Death                                                                                  |                                                                                    | R/Outpatient 3 DOA Carer 4 Nursing 18b. Time of Injury 28c. Injury at Work?                       | 28d. Describe how in                                                    |                                                                      |
| Division of Vital | uttendir<br>death.<br>ctor: Al                                                                                                                                                                                                                                                                       | icatle              | 2 Accident investigation                                                                             |                                                                                    | M 1 ☐ Yes 2 ☐ No                                                                                  | 28t Location /Street                                                    | and Number or Rural Route Number,                                    |
| 2                 | el or Attenes<br>s after death<br>Il Director:<br>d in by the                                                                                                                                                                                                                                        | Certification;      | 4 Homicide determined                                                                                | building, etc. (Specify)                                                           | e, farm, street, factory, office                                                                  | City or Town, St                                                        |                                                                      |
|                   | o the Hospitel<br>thin 24 hours a<br>the Funerel I<br>mpletely filled                                                                                                                                                                                                                                |                     | (Check only 2 Medical Examiner:                                                                      | On the basis of examinatio                                                         | edge, death occurred at the time, date and plan and/or investigation, in my opinion, death of     | ace, and due to the cause<br>ccurred at the time, date                  | e(s) and manner as stated. and place, and due to the cause(s)        |
|                   | To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune                                                                                                                                                                            | Medical             | 29b. Signature and title of dertition                                                                | and manner stated.                                                                 | 29c. License number                                                                               | 29d.                                                                    | Date signed (Month, Day, Year)                                       |
|                   | ~                                                                                                                                                                                                                                                                                                    |                     | Lallo                                                                                                | > M.D                                                                              | D6338                                                                                             | 2 F                                                                     | e BRICKY 26 2008                                                     |
| 3                 | 1                                                                                                                                                                                                                                                                                                    |                     | 30. Name and address of person who completed to the Ray                                              | eted cause of death (Item 2)                                                       |                                                                                                   | Pinelis                                                                 | ,                                                                    |
|                   | Sta                                                                                                                                                                                                                                                                                                  | te                  | 31. Date filed (Month, Day, Year)                                                                    | 32 Registrar's Signatur                                                            |                                                                                                   | 5 21239                                                                 |                                                                      |
|                   | Registr                                                                                                                                                                                                                                                                                              | ar                  | FEB 2 9 2008                                                                                         | Page M                                                                             | Angell 8                                                                                          |                                                                         |                                                                      |

|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | State of Maryland / Department of Health and M  1- State Registrar Certificate of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                    | ene 008                       | 06286                                |
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|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | Decedent's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2. Date of Death                   |                               | 3. Time of Death                     |
|                            | Physici                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               | James H. Murphy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Month<br>02-26-2                   | Day Year<br>008               | 1506 <sup>™</sup>                    |
|                            | /Medic<br>Examir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                               | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                    | 4c. County of Dea             | th                                   |
|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | Harford Memorial Hospital Havre de Grace                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                    | Harford                       |                                      |
|                            | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 8. Date of Birth<br>(Month, Day, ) | (ear) C                       | thplace (State or Foreign<br>ountry) |
|                            | Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               | 215-07-4371   X M 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 11-03-19                           | 918   Ma                      | aryland                              |
|                            | land                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                               | 10a. State 10b. County 10c. City, Town or Location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                    |                               | 10d. Inside City Limits              |
|                            | Many                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | tor                           | Maryland Harford Bel Air                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                    |                               | 1 □ Yes 2X□ No                       |
|                            | or 284                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | irec                          | 10e. Street and Number 10f. Zip Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 100                                | g. Citizen of What C          | ountry?                              |
|                            | 23a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | la                            | 555 S. ATwood Rd Apt 404 21014                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                    | U.S.A.                        |                                      |
|                            | teme<br>reme                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | une                           | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Spell Free Process) If Yes, specify Cuban, Mexican, Puerto                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | cify Yes or No-<br>Rican, etc.)    | 14. Race - Am<br>Black, Whi   |                                      |
| 36                         | rs afte                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | y F                           | 1 Never Married 2 Married 1 No 1 Yes 2 No 1 Yes, Give 1 Yes, Sive 1 Yes 2 No Specify: Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                    | Specify: W                    | hite                                 |
| 21215-0036                 | 72 hours after deeth with the Maryland<br>naturel', or iteme 23a or 28e-f ehow<br>direl Examiner must be notilised at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Completed by Funeral Director | 15 Decedent's Education 16a Decedent's Usual Occupation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 16                                 | 3b. Kind of Business          | <del></del>                          |
| 215                        | hin 7.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | pie                           | (Specify only highest grade completed)  [Give kind of work done during most of working the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties | ng                                 |                               |                                      |
| 21                         | od wit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Com                           | 5 Electric Welder                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                    |                               | ing Electron.                        |
| nd                         | be file<br>tal Hy<br>d oth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Be                            | 17. Father's Name (First, Middle, Last)  Robert D. Murphy  18. Mother's Name Hattie C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                    |                               |                                      |
| Уa                         | ould<br>Men<br>Marke<br>Marke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                    |                               | 7'- O- d- )                          |
| Maryland                   | is 1 end 2 should be filed within 72 hours after deeth with the Marylan of Heatth and Mental Hygiene. Item 27 is marked other than *natural', or iteme 23a or 28a-1 ehow other traumatic avent. The Medical Examiner must be neitlised as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                               | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                    | 500000                        | Zip Code)                            |
|                            | Healt<br>Healt<br>Healt<br>Her                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | - 10                          | Steven Sipes (Grandson) 2702 Beckon Dr Edgewood  20a. Method of Disposition (Name of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                    | J4U<br>Dc. Location - City or | Town, State                          |
| ou                         | ages<br>ont of<br>t: If it                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               | 1 \( \text{\text{Memod of Disposition}} \)  1 \( \text{\text{\text{Donation}}} \) 2 \( \text{\text{Cremation}} \) 3 \( \text{\text{Removal from State}} \)  4 \( \text{\text{Donation}} \) 5 \( \text{\text{Other}} \( (Specify) \)  MD \( \text{National Mem' 1 Park} \) 02-29                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2009 T.                            | urol Mai                      | cv1 and                              |
| Baltimore,                 | permit. Pages 1 end<br>Department of Healt<br>Important: If item 2<br>any Injury or other<br>once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sch                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                    |                               |                                      |
| B                          | permit. Departr Importe any inju                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                               | Inc. 610 W. MacPhail                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | l Rd Bel                           | Air, MD                       | 21014                                |
|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | r respiratory arres                | st,                           | Approximate<br>Interval Between      |
|                            | Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                               | Immediate Cause (Final disease or condition CORMANY ARTEN DISEASE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                    |                               | Onset and Death                      |
| 1                          | /Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                               | resulting in death)  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                    |                               |                                      |
|                            | Examine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | _                             | Sequentially list conditions, b. Due to (or as a consequence of).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                    |                               |                                      |
| 1                          | nslt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Examiner                      | cause. Enter Underlying Cause (Disease or injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                    |                               |                                      |
| V.                         | al-tra                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Exar                          | that initiated events resulting in death) Last Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                    |                               |                                      |
| 8760,                      | The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | dical                         | d. =                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                    |                               |                                      |
| 9                          | rtificat<br>ng phy<br>as th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 0                             | IS FEWALE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                    |                               |                                      |
| Вох                        | th ce<br>tendii                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | an/h                          | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                    | 23d. Date of de<br>Month      | livery<br>Day Year                   |
|                            | that the death certific<br>ed by the ettending p<br>detached for use as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Physician/M                   | 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                    |                               | J.,                                  |
| P.O.                       | that the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | P.                            | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 23e. Did toba                      | icco use contribute (         | o the cause of death?                |
| ds,                        | uires<br>signi<br>ld be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | d by                          | CONGESTIVE HEART FAILURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1 ☐ Yes                            | 2 □ No 3 □ P                  | robably 4 Unknown                    |
| 9                          | w require<br>been si<br>should I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Completed                     | 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 24a. Was an                        | 24b. Were a                   | utopsy findings available            |
| Re                         | The lav                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | dwo                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | autopsy<br>performy<br>1 Yes 2     | ed? death?                    | completion of cause of               |
| ta                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0                             | 25. Was case referred to medical 26. Place of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                    | A                             | 2010                                 |
| <b>&gt;</b>                | Physicien:<br>this certificatal director, i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | To B                          | examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Hor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | me 5 ☐ Residen                     | ce 6 □Other (Spe              | ecify)                               |
| 0                          | ng Pl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               | 1 Natural 5 Pending (Month, Day Year) Injury Work?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 28d. Describe how                  | vinjury occurred              |                                      |
| sio                        | tendi<br>leath.<br>tor: A<br>the fu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | cati                          | 2 Accident investigation M 1 Yes 2 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 20f Leasting /Ctra                 | et and Number or F            | humi Dauta Number                    |
| Division of Vital Records, | or All<br>efter of<br>Direction by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Certification;                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | City or Town,                      |                               | Brai riodie Nulliber,                |
|                            | apital<br>iours<br>neral<br>filled                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               | Pla Cartifer 1 Confliging Physician: To the best of my knowledge death occurred at the time date and place of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | and due to the cau                 | ise(s) and manner a           | s stated                             |
|                            | To the Hospital or Attending Physicien: within 24 hours eiter death. To the Funeral Director: Atter this certific completely filled in by the funeral director.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Medicai                       | (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ed at the time, dat                | e and place, and du           | e to the cause(s)                    |
|                            | To the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of the troit of th | Σ                             | 29b. Signature and title of certifier 29c. License number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                    | d. Date signed (Mor.          |                                      |
| ,                          | 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               | D0056296                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                    | 2-26-                         | 2000                                 |
| (                          | 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JASON BIRNDAUM, MD 501 S. UNION AVE HAVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ( 1 1 1                            | 11.                           | 2/070                                |
| 2                          | -01                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               | JASON BIRNDAUM, MD 501 S. UNION AVE HAW  31. Date filed (Month, Day, Year)  32. Degistrar's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | real of                            | RACE, MID                     | 21018                                |
|                            | Sta<br>Registr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               | FEB 2 9 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                    |                               |                                      |
|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                    |                               |                                      |

James Murphy

7/26/08 DOD 1506

|                                                                                                                                                                                                                                                                                                                                                                        | Pleas                                                                                                                                                                                                                                                                                                                                                         | e Type or Print                                                                                                                   | in Blac                          | k Indelible l                                                     | nk. Ensu                                | re All C                                                                       | opies A                                                   | e Legible.                                     |                                              |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------|----------------------------------------------|--|--|
|                                                                                                                                                                                                                                                                                                                                                                        | State of Maryland / Department of Health and                                                                                                                                                                                                                                                                                                                  |                                                                                                                                   |                                  |                                                                   |                                         | and Men                                                                        | Mental Hygiene                                            |                                                |                                              |  |  |
|                                                                                                                                                                                                                                                                                                                                                                        | 1 - State Registrar  1. Decedent's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                 |                                                                                                                                   |                                  | Certificate                                                       | of Death                                | 101                                                                            | Reg.                                                      | 3. Time of Death                               |                                              |  |  |
| Physician                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                               | D. Martell                                                                                                                        | 0                                |                                                                   |                                         | -                                                                              | Month                                                     | Day Year                                       | 3.22P M                                      |  |  |
| /Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                   | 4a. Facility Name (If not institution,                                                                                                                                                                                                                                                                                                                        |                                                                                                                                   |                                  | 4b. City, Tov                                                     | vn, or Location o                       |                                                                                | bruary                                                    | 26,200 8<br>4c. County of Deal                 | h                                            |  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                    | Franklin Squa<br>5. Social Security Number<br>217-16-4651                                                                                                                                                                                                                                                                                                     |                                                                                                                                   | Cent<br>(In yrs. last bir.<br>83 | thday) If Under 1 Y                                               | Roseda<br>ear If Under 2<br>ays Hours   |                                                                                | Date of Birth<br>Month, Day, Yo                           | Balt<br>924 9. Bird<br>Co                      | thplace (State or Foreign MD                 |  |  |
| pun &                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent  10a. State 10b. County                                                                                                                                                                                                                                                                                                           |                                                                                                                                   | 10c. City, Tow                   | n or Location                                                     |                                         |                                                                                |                                                           |                                                | 10d. Inside City Limits                      |  |  |
| r 28a-f show<br>i notified at<br>irector                                                                                                                                                                                                                                                                                                                               | MD Baltimore Middle River                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                   |                                  |                                                                   |                                         |                                                                                |                                                           | 1 □Yes 2 🔀 No                                  |                                              |  |  |
| ₹ ° % □                                                                                                                                                                                                                                                                                                                                                                | 10e. Street and Number 407 Ballard                                                                                                                                                                                                                                                                                                                            | 10e. Street and Number 407 Ballard Avenue                                                                                         |                                  |                                                                   | 10f. Zip Code 21220                     |                                                                                |                                                           |                                                | 10g. Citizen of What Country?                |  |  |
| urs after death wall, or items 23a Examiner must l                                                                                                                                                                                                                                                                                                                     | 3 ∰Widowed 4 ☐ Divorced                                                                                                                                                                                                                                                                                                                                       | 12. Was Decedent Ev<br>Armed Forces?<br>1 ☐ Yes 2 🕱 No<br>If Yes, Give<br>Year or Dates:                                          |                                  | 13. Was Decedent If Yes, specify                                  |                                         | gin? (Specify<br>i, Puerto Rica                                                | Yes or No-<br>in, etc.)                                   | 14. Race - Ame<br>Black, Whit<br>Specify: W    |                                              |  |  |
| permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami once.  To Be Completed by F                                                                                                                         | 15. Decedent's (Specify only highest Elementary/Secondary (0-12)                                                                                                                                                                                                                                                                                              | s Education<br>grade completed)<br>College (1-4or 5+                                                                              | ,                                | Decedent's Usual O<br>(Give kind of work d<br>life. DO NOT use re | ccupation<br>one during most<br>etired) | of working                                                                     |                                                           | b. Kind of Business/                           | Industry                                     |  |  |
| led wi<br>tygien<br>her th<br>nt, the                                                                                                                                                                                                                                                                                                                                  | 10th                                                                                                                                                                                                                                                                                                                                                          | act)                                                                                                                              | Н                                | omemaker                                                          | 19 Motha                                | r's Nama <i>(Fi</i>                                                            |                                                           | own home                                       |                                              |  |  |
| d be fill Hed out teed out ceven                                                                                                                                                                                                                                                                                                                                       | 17. Father's Name (First, Middle, Last) Petro DelCostello                                                                                                                                                                                                                                                                                                     |                                                                                                                                   |                                  |                                                                   |                                         |                                                                                | (First, Middle, Maiden Surname)                           |                                                |                                              |  |  |
| should be<br>and Mental<br>s marked of<br>umatic even                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                   |                                  |                                                                   |                                         | dress (Street and Number or Rural Route Number, City or Town, State, Zip Code) |                                                           |                                                |                                              |  |  |
| and 2<br>ealth a<br>n 27 is<br>er trau                                                                                                                                                                                                                                                                                                                                 | Denise Martel                                                                                                                                                                                                                                                                                                                                                 | lo /daught                                                                                                                        |                                  |                                                                   |                                         |                                                                                | e Fore                                                    | stville                                        | MD 20747                                     |  |  |
| Pages 1<br>nent of He<br><b>nnt: If iten</b><br><b>nry or oth</b>                                                                                                                                                                                                                                                                                                      | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Cardens of Faith  20c. Location - City or Town, State  Rossville MD                                                                                                               |                                                                                                                                   |                                  |                                                                   |                                         |                                                                                |                                                           |                                                |                                              |  |  |
| permit. Departi Imports any inj                                                                                                                                                                                                                                                                                                                                        | 21. Signature of uneral Service Licensee  22. Name and Address of Facility 300 Mace Ave. Balto. MD  Connelly Funeral Home of Essex 21221                                                                                                                                                                                                                      |                                                                                                                                   |                                  |                                                                   |                                         |                                                                                |                                                           |                                                |                                              |  |  |
| Physician<br>/Medical                                                                                                                                                                                                                                                                                                                                                  | 23a. Part . Enter the disease, or o<br>shock, or heart failure. List of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)                                                                                                                                                                                                              | _a. MP:                                                                                                                           | TASTE                            | TIC C                                                             | dying, such as<br>ARCI w                |                                                                                | -                                                         | 4                                              | Approximate Interval Between Onset and Death |  |  |
| Examiner ច                                                                                                                                                                                                                                                                                                                                                             | Se uentially list conditions, if any, leading to immediate                                                                                                                                                                                                                                                                                                    | Due to (or as a consequence of):  Se juentially list conditions, it any leading to immediate  b. Due to (or as a consequence oi). |                                  |                                                                   |                                         |                                                                                |                                                           |                                                |                                              |  |  |
| e executed sian and urial-transit                                                                                                                                                                                                                                                                                                                                      | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events<br>resulting in death) Last                                                                                                                                                                                                                                                      | consequence                                                                                                                       | 2) of CHRONE Rep FAIL            |                                                                   |                                         |                                                                                |                                                           | 5+4                                            |                                              |  |  |
| ficate be<br>physicial<br>s the bu                                                                                                                                                                                                                                                                                                                                     | d                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                   |                                  |                                                                   |                                         |                                                                                |                                                           |                                                |                                              |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Medical Certification: To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                                                                                                                                                                                                                                                       |                                                                                                                                   |                                  |                                                                   |                                         |                                                                                |                                                           | 23d. Date of de<br>Month                       | 23d. Date of delivery<br>Month Day Year      |  |  |
| uires that signed by ld be deta                                                                                                                                                                                                                                                                                                                                        | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                        |                                                                                                                                   |                                  |                                                                   |                                         |                                                                                | 23e. Did tobacco use contribute to the cause of death?  1 |                                                |                                              |  |  |
| : The law requi                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                   |                                  |                                                                   |                                         | _                                                                              |                                                           | autopsy prior to completion of cause of death? |                                              |  |  |
| cian: certifica sector, p                                                                                                                                                                                                                                                                                                                                              | 25. Was case referred to medical                                                                                                                                                                                                                                                                                                                              |                                                                                                                                   |                                  |                                                                   | 26. Place                               | of Death (CI                                                                   | 1∐ Yes 2 <b>t</b> ⊾<br>heck only one)                     | eno in tes                                     | 5 2 NO                                       |  |  |
| hysic<br>this ce<br>al direc                                                                                                                                                                                                                                                                                                                                           | 1 Yes 2 No Prospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (S                                                                                                                                                                                                                                                          |                                                                                                                                   |                                  |                                                                   |                                         |                                                                                |                                                           |                                                | ecify)                                       |  |  |
| eath. or: After the funerather                                                                                                                                                                                                                                                                                                                                         | 1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No                                                                                                                                                                                                                                                            |                                                                                                                                   |                                  |                                                                   |                                         |                                                                                | 28d. Describe how injury occurred                         |                                                |                                              |  |  |
| To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Compl                                                                                                                                              | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. L                                                                                                                                                                                                                         |                                                                                                                                   |                                  |                                                                   |                                         | Location (Street and Number or Rural Route Number,<br>City or Town, State)     |                                                           |                                                |                                              |  |  |
| o the Hosp<br>ithin 24 hou<br>o the Fune<br>ompletely fil                                                                                                                                                                                                                                                                                                              | 29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                   |                                  |                                                                   |                                         |                                                                                |                                                           |                                                |                                              |  |  |
| To To Con                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                   |                                  |                                                                   |                                         |                                                                                |                                                           | e signed (Month, Day, Year)                    |                                              |  |  |
| ,                                                                                                                                                                                                                                                                                                                                                                      | 30. Name and address of person w                                                                                                                                                                                                                                                                                                                              | the completed source of de-                                                                                                       | ath (Itom 00a)                   | (T - D: 1)                                                        |                                         |                                                                                |                                                           | 2.26.                                          | . OS                                         |  |  |
| 6                                                                                                                                                                                                                                                                                                                                                                      | J. A. FR                                                                                                                                                                                                                                                                                                                                                      | 22 WI My 22                                                                                                                       | 3 12 , 19                        | Sho BAL                                                           | T 140 2                                 | 2/201                                                                          |                                                           |                                                |                                              |  |  |
| State<br>Registrar                                                                                                                                                                                                                                                                                                                                                     | 31. Date filed (Month, Day, Year)                                                                                                                                                                                                                                                                                                                             | 1) 2008 August 2008                                                                                                               | 's Signature                     | y posti                                                           | 9                                       | ,                                                                              |                                                           |                                                |                                              |  |  |

|                            |                                                                                                                                              |                                                                                                    | _                                                                                                                                                                                                                                                                                                                                                             | pe or Print in                               |                   |                                                       |                                          |                                      | •                             |                                                   |  |
|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-------------------|-------------------------------------------------------|------------------------------------------|--------------------------------------|-------------------------------|---------------------------------------------------|--|
|                            |                                                                                                                                              |                                                                                                    |                                                                                                                                                                                                                                                                                                                                                               | State of Marylar                             | -                 |                                                       |                                          | Mental Hy                            | giene                         | 0.0000                                            |  |
|                            |                                                                                                                                              |                                                                                                    | 1 - State<br>Registrar                                                                                                                                                                                                                                                                                                                                        |                                              | Ce                | rtificate of                                          | Death                                    |                                      | Reg. No. 🗸 📗 📗                | 0 05200                                           |  |
|                            | Physici                                                                                                                                      | an                                                                                                 | Decedent's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                         |                                              |                   |                                                       |                                          | 2. Date of De<br>Month               | Day_ Year                     |                                                   |  |
|                            | /Medical Michael Moerschel                                                                                                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                                                                               |                                              |                   | 41. Oit. T                                            |                                          | 12                                   | т                             | 8                                                 |  |
| ,                          | Examir                                                                                                                                       | Examiner  4a. Facility Name (If not institution, give street and number)  FRANKLIN SQUARE HOSPITAL |                                                                                                                                                                                                                                                                                                                                                               |                                              |                   | 4b. City, Town, or Location of Death  Center Rosedale |                                          |                                      | 4c. County of De              | im or e                                           |  |
|                            | Funeral                                                                                                                                      |                                                                                                    | 5. Social Security Number 6. Sex                                                                                                                                                                                                                                                                                                                              | 7. Age (In yrs                               |                   |                                                       | If Under 24 Hrs                          |                                      | th 9. Bi                      | rthplace (State or Foreign                        |  |
|                            | Director                                                                                                                                     |                                                                                                    |                                                                                                                                                                                                                                                                                                                                                               | <sup>M 2□ F</sup> 53                         | Yrs.              | Months Days                                           |                                          |                                      | v, Year)                      | MD                                                |  |
|                            | 72 hours after death with the Maryland<br>natural", or items 23a or 28a-f show<br>di~al Examiner must be notified at                         |                                                                                                    | 10a. State 10b. County                                                                                                                                                                                                                                                                                                                                        | 10c. C                                       | ty, Town or Lo    | ocation                                               |                                          | -                                    |                               | 10d. Inside City Limits                           |  |
|                            | ter death with the Marylan<br>items 23a or 28a-f show<br>Iner must be notified at                                                            | ţċ                                                                                                 | MD Baltimore N/A                                                                                                                                                                                                                                                                                                                                              |                                              |                   |                                                       |                                          |                                      |                               | 1 □ Yes 2 No                                      |  |
|                            | th the                                                                                                                                       | To Be Completed by Funeral Director                                                                | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                        | · · · · · · · · · · · · · · · · · · ·        |                   | 10f. Zip Code                                         |                                          |                                      | 10g. Citizen of What C        | ountry?                                           |  |
|                            | 23a ust b                                                                                                                                    |                                                                                                    | 3508 Buckboard                                                                                                                                                                                                                                                                                                                                                | Lane                                         |                   | 21220                                                 |                                          |                                      | U.S.A.                        |                                                   |  |
|                            | r dea                                                                                                                                        |                                                                                                    | 111 Harris Grand                                                                                                                                                                                                                                                                                                                                              | . Was Decedent Ever in t<br>Armed Forces?    | J.S. 13.          | Was Decedent of H<br>If Yes, specify Cub              | Hispanic Origin? (S<br>an, Mexican, Puer | Specify Yes or No<br>to Rican, etc.) | 14. Race - Am<br>Black, Wh    |                                                   |  |
| 36                         | s afte                                                                                                                                       |                                                                                                    | 1 Never Married 2 Married 1 Yes 2 No                                                                                                                                                                                                                                                                                                                          |                                              |                   | 1 ☐ Yes 2 No Specify:                                 |                                          |                                      |                               | Specify: White                                    |  |
| 8                          | be filed within 72 hours aff<br>ntal Hygiene.<br>ed other than "natural", or<br>event, the Medical Exa <u>ml</u>                             |                                                                                                    | 3 Widowed 4 Divorced                                                                                                                                                                                                                                                                                                                                          | Year or Dates:                               | 10- D             | dent's Usual Occur                                    |                                          |                                      |                               |                                                   |  |
| 15                         | n 72<br>"nat                                                                                                                                 |                                                                                                    | 15. Decedent's Educa<br>(Specify only highest grade of                                                                                                                                                                                                                                                                                                        | tion<br>completed)                           | Give              | kind of work done  DO NOT use retire                  | pation<br>during most of wo<br>d)        | rking                                | 16b. Kind of Busines          | s/Industry                                        |  |
| 12                         | within 7 iene.                                                                                                                               |                                                                                                    | Elementary/Secondary (0-12)                                                                                                                                                                                                                                                                                                                                   | College (1-4or 5+)                           |                   | g Helpe                                               | *                                        |                                      | Beer Dis                      | tribution                                         |  |
| d 2                        | e filed<br>al Hygi<br>other<br>vent, ti                                                                                                      |                                                                                                    | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                       |                                              | 1                 | 8                                                     |                                          | me (First, Middle,                   | . Maiden Surname)             |                                                   |  |
| lan                        | id be<br>ental<br>ked c                                                                                                                      |                                                                                                    | Henry Moersche                                                                                                                                                                                                                                                                                                                                                | 1                                            |                   |                                                       | Minnie                                   | Stewa                                | rt                            |                                                   |  |
| ary                        | 2 should and Men Is marke                                                                                                                    |                                                                                                    | 19a. Informant's Name/Relationship (Type                                                                                                                                                                                                                                                                                                                      |                                              | 19b. Maili        | ng Address (Street                                    |                                          |                                      | er, City or Town, State,      | Zip Code)                                         |  |
| ore, N                     | s 1 and 2 should<br>if Health and Mer<br>item 27 Is marke<br>other traumatic                                                                 |                                                                                                    | Sheila Moersche                                                                                                                                                                                                                                                                                                                                               | 1/Wife                                       | 3508              | Buckbo                                                | ard Lar                                  | e. Mid                               | dle River                     | , MD 21220                                        |  |
|                            | of Heritem                                                                                                                                   |                                                                                                    | 20a. Method of Disposition                                                                                                                                                                                                                                                                                                                                    | 20b.                                         | Place of Dispo    | osition (Name of matory or other pla                  | ice)                                     | Date                                 | 20c. Location - City of       |                                                   |  |
|                            | Pages<br>nent of I<br>int: If its<br>iry or o                                                                                                |                                                                                                    | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer<br>4 ☐ Donation 5 ☐ Other (Specify)                                                                                                                                                                                                                                                                                          |                                              |                   | ake Cre                                               | m. 02.                                   | 28.08                                | Beltsvill                     | e, MD                                             |  |
| Balti                      | permit. Pag<br>Department<br>Important: I<br>any injury o                                                                                    | ļ                                                                                                  | 21. Signature of Funeral Service Licensee                                                                                                                                                                                                                                                                                                                     | TO M0144.                                    |                   |                                                       |                                          |                                      | phen D. L<br>res Dr. B        |                                                   |  |
|                            | *                                                                                                                                            |                                                                                                    | 23a. Part1. Enter the disease, or complica                                                                                                                                                                                                                                                                                                                    | itions that caused the dea                   |                   |                                                       |                                          |                                      |                               | Approximate                                       |  |
|                            | Physician                                                                                                                                    | 3                                                                                                  | shock, or heart failure. List only one<br>Immediate Cause (Final                                                                                                                                                                                                                                                                                              |                                              |                   |                                                       |                                          |                                      |                               | Interval Between<br>Onset and Death               |  |
|                            | /Medical                                                                                                                                     |                                                                                                    | disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                      | Sepsis  Due to (or as a conse                | quence of):       |                                                       |                                          |                                      |                               |                                                   |  |
|                            | Examiner                                                                                                                                     | ıer                                                                                                | End store Liver disease                                                                                                                                                                                                                                                                                                                                       |                                              |                   |                                                       |                                          |                                      |                               |                                                   |  |
| 1                          |                                                                                                                                              |                                                                                                    | Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury                                                                                                                                                                                                                                                  | Due to (or as a conse                        |                   |                                                       |                                          |                                      |                               |                                                   |  |
| $\vee$                     | executed<br>in and<br>rial-transit                                                                                                           | Examine                                                                                            | Cause (Disease or injury that initiated events                                                                                                                                                                                                                                                                                                                | GI B                                         |                   |                                                       |                                          |                                      |                               |                                                   |  |
| . '09                      | an ar                                                                                                                                        |                                                                                                    | resulting in death) Last                                                                                                                                                                                                                                                                                                                                      | quence of):                                  |                   |                                                       |                                          |                                      |                               |                                                   |  |
|                            | eath certificate be executed<br>attending physician and<br>for use as the burial-transit                                                     | <u>g</u>                                                                                           |                                                                                                                                                                                                                                                                                                                                                               |                                              |                   |                                                       |                                          |                                      |                               |                                                   |  |
| (687                       | death certificate<br>e attending physi<br>ed for use as the                                                                                  | Physician/Medica                                                                                   | IF FEMALE:                                                                                                                                                                                                                                                                                                                                                    |                                              |                   |                                                       |                                          |                                      |                               |                                                   |  |
| Вох                        | ath ce<br>tendi                                                                                                                              | an/                                                                                                | 23b. Was decedent pregnant in the past 12 months?                                                                                                                                                                                                                                                                                                             |                                              | ∃Ectopic pregnanc |                                                       | 23d. Date of delivery<br>Month Day Year  |                                      |                               |                                                   |  |
| O. E.                      | O O O                                                                                                                                        | sici                                                                                               | 1 ☐ Yes 2 ☐ No                                                                                                                                                                                                                                                                                                                                                | death 5                                      | Other (specify)   | Month                                                 |                                          |                                      |                               |                                                   |  |
| P.0.                       | law requires that the de<br>as been signed by the a<br>2 should be detached f                                                                | Phy                                                                                                | 9 Unknown 9Unknown                                                                                                                                                                                                                                                                                                                                            |                                              |                   |                                                       |                                          |                                      | -h                            |                                                   |  |
| Š,                         | res th                                                                                                                                       | by                                                                                                 | 256. Did tobacco using the underlying cause given in Part 1.                                                                                                                                                                                                                                                                                                  |                                              |                   |                                                       |                                          |                                      |                               |                                                   |  |
| or.                        | w require<br>been sign                                                                                                                       | Completed                                                                                          |                                                                                                                                                                                                                                                                                                                                                               |                                              |                   |                                                       |                                          |                                      | es 2 No 3 Probably 4 donknown |                                                   |  |
| 3ec                        | has by                                                                                                                                       | nple                                                                                               |                                                                                                                                                                                                                                                                                                                                                               |                                              |                   |                                                       |                                          | 24a. Was<br>autoj                    | osy prior to                  | autopsy findings available completion of cause of |  |
| al<br>F                    | ate ⊤                                                                                                                                        | S                                                                                                  |                                                                                                                                                                                                                                                                                                                                                               |                                              |                   |                                                       |                                          | perio<br>1∐ Yes                      | ormed? death?<br>2☑No 1☐Ye    |                                                   |  |
| Division or Vital Records, | <b>Attending Physician:</b> The le r death.<br>ector: After this certificate had by the funeral director, page 2                             | Be                                                                                                 | 25. Was case referred to medical examiner?                                                                                                                                                                                                                                                                                                                    | spital:                                      |                   | Oth                                                   |                                          | ath (Check only o                    | nne)                          |                                                   |  |
| o                          | Phys<br>this                                                                                                                                 | 2                                                                                                  | 1 Yes 2 No                                                                                                                                                                                                                                                                                                                                                    | 1 Inpatient 2                                | ER/Outpatier      |                                                       | 4 LI Nursing F                           |                                      | dence 6 □Other (Sp            | ecify)                                            |  |
| no                         | ding<br>J.<br>After<br>fune                                                                                                                  | ion                                                                                                | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Work?                                                                                                                                                                                                                                      |                                              |                   |                                                       |                                          |                                      |                               |                                                   |  |
| isi                        | death<br>ctor:<br>/ the                                                                                                                      | icat                                                                                               | 2 Accident investigation 3 Suicide 6 Could not be                                                                                                                                                                                                                                                                                                             | 28e. Place of injury - At h                  | ome farm str      |                                                       |                                          |                                      |                               |                                                   |  |
| <u>Ş</u>                   | lor A<br>after<br>Dire                                                                                                                       | Certification:                                                                                     | 4 Homicide determined                                                                                                                                                                                                                                                                                                                                         | eet, factory, office 28f. Location (Street a |                   |                                                       |                                          |                                      |                               |                                                   |  |
| _                          | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After thi<br>completely filled in by the funeral |                                                                                                    | 29a. Certifier 1 Certifying Physic                                                                                                                                                                                                                                                                                                                            | ian: To the best of my kn                    | owledge, deat     | h occurred at the ti                                  | me, date and plac                        | e, and due to the                    | cause(s) and manner a         | as stated.                                        |  |
|                            | e Ho<br>24 h<br>e Fui<br>letely                                                                                                              | Medical                                                                                            | 29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                              |                   |                                                       |                                          |                                      |                               |                                                   |  |
|                            | To th<br>within<br>To th                                                                                                                     | Me                                                                                                 | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                         |                                              |                   | 29c. License number 25                                |                                          |                                      |                               | d. Date signed (Month, Day, Year)                 |  |
|                            |                                                                                                                                              |                                                                                                    |                                                                                                                                                                                                                                                                                                                                                               |                                              |                   |                                                       | D36663                                   |                                      |                               | 2-25-08                                           |  |
|                            | 6                                                                                                                                            |                                                                                                    | 30. Name and address of person who com                                                                                                                                                                                                                                                                                                                        | pleted cause of death (Ite                   | m 23a) (Type,     | Print)                                                |                                          |                                      | <u> </u>                      | _                                                 |  |
|                            | 9                                                                                                                                            |                                                                                                    | DR STUART R. Willes                                                                                                                                                                                                                                                                                                                                           | 5 9000 FAR                                   | INKLIN            |                                                       | e DR                                     | Baltin                               | nore mo                       | 121237                                            |  |
|                            | Sta                                                                                                                                          |                                                                                                    | 31. Date filed (Month, Day, Year)                                                                                                                                                                                                                                                                                                                             | 32. Registrar's Sign                         | ature             |                                                       |                                          |                                      |                               | <u> </u>                                          |  |
|                            | Registr                                                                                                                                      | ar                                                                                                 | FEB 2 9 2008                                                                                                                                                                                                                                                                                                                                                  | Bereve 1                                     | N An              | sell!                                                 |                                          |                                      |                               |                                                   |  |
| DH                         | MH 17 Rev 1/20                                                                                                                               | 001                                                                                                | ·                                                                                                                                                                                                                                                                                                                                                             |                                              |                   |                                                       |                                          |                                      |                               |                                                   |  |
|                            |                                                                                                                                              |                                                                                                    |                                                                                                                                                                                                                                                                                                                                                               |                                              | ORI               | GINAL                                                 |                                          |                                      |                               |                                                   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01599 State of Maryland / Department of Health and Mental Hygiene Julius Pressley 2008 05289 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day February 24, 2008 2252 hrs Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death ne (if not institution, give street and number) Baltimore Johns Hopkins Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 2\_\_\_F Yrs. 10d. Inside City Limits 10c, City, Town or Location 10a, State 10b. County 23a or 28a-f shov notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland irectol 10g. Citizen of What Country? 10e. Street and Number ö 14. Race - American Indian, Black, Funeral . Was Decedent of Hispanic Origin? ( Specify Yes or Noor items White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Yes 2 No specify: Divorced Yes Widowed 4 þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) marked other than " Baltimore, MD 21215-0036 Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Rout t: If item 27 is n other traumatic 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State tant: Donation 5 Other Specify: Signature of Funeral Service Licensee Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. mode of dying such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - trar Physician/Medical AMENDED UNPENDED rds, P.O. Box 68760, requires that the death certificate be 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has { performed? death? ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other<sub>4</sub> Hospital: 1 🗸 Inpatient 2 Nursing Home 5 Residence 6 Other: DOA ER/Outpatient 1 V Yes After this ို 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: Subject shot Feb 24, 2008 2037 hrs Natural Yes 2 V No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City

Division of Vital Records, P.O. Director: 24 hours after death To the Funeral Medical

within ?

30. Name and address of person who completed cause of death (Item 23a)

Could not be

determined

29c. License number O.C.M.E.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) February 25, 2008

or Town, State) 2500 E. Chase Street, Baltimore, MD

111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

32. Redistrar's Signature

(Specify) Local Street

31. Date filed (Month, Day, Year) State Registra

Suicide

2 🗸

29b. Signature and title of certifier

4 V Homicide 29a. Certifier 1

3

28e. Place of Injury - At home, farm, street, factory, office building, etc.

and manner stated

Division or Vital Records. P.O. Box 68760. the Hospital or Attending after death

Baltimore, Maryland 21215-0036

After this certificate has been signed by funeral director, page 2 should be detact

Medical

1604

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SARAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

investigation

6 Could not be determined

R. BARAL, MI

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Ly Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2185

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 -Year -2008 Name (If not institution, give street and number) 4c. County of Death LTIMORE TATION EXTENDED CARE NIA If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1□M 2□F 219-22-4042 Jan 14, 1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No N/A **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1031 North Gilmor Street 21217 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∏Yes 2 ☐ No If Yex, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1950 Specify Specify 3 ☐ Widowed 4 ☐ Divorced Black 1054 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Superior Whitehouse Warehouseman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Riley Niece 1031 North Gilmor Street Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/01/08 Owings Mills, Md. **Garrison Forest Veterans Cemetery** 21. Signat r Pheral Service icens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the diseas shock, or heart failure. ease, or complications that caused the death. re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNKNOWI Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2XNo 2 ER/Outpatient 3 DOA 1 Inpatient

**Examiner** law requires that the death certificate be executed burial-trar P.O. Box 68760, the l as attending p nse been signed by the should be detached Division or Vital Records, page certificate or Attending Physician: this

Physician

/Medical

**Examiner** 

Director

Funeral

þ

Completed

Be ပ

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

filed within 72 hours after death ! Hygiene,

permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: if item 27 is marked other the any fujury or other traumatic event, the once.

Physician

/Medical

Examiner

Physician/Medical

Baltimore, Maryland 21215-0036

Completed by filled in by the funeral director, Certification: To Be death. after death To the Hospital within 24 hours a To the Funeral C Hospital Medical completely

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 6:45P M MICHAEL ANTHONY PROCTOR FEBRUARY 24, 2008 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HUGHESVILLE CHARLES 17140 TALL TIMBER PLACE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **XX**M 2□ F Yrs Director 579-50-2939 67 11-29-1940 Washington, DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f sh notified YYes 2 No Director MD Charles <u>Hughesville</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or 17140 Tall Timber Place 20637 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: Black 2 Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5YRS. + Orthopedic Surgeon Self Employed Department of Health and Mental Important: If item 27 is any Injury or office. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice Welsh Margaret Rigely 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erlease Proctor/ Wife 17140 Tall Timber Place, Hughesville, MD 20637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metropolitan Crematory03-03-2008 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
MARSHALL S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Dementia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ X No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2421No 1□ Yes

Division or Vital Records, P.O. Box 68760 or Attending Physician: Director:

upletely filled in by the funeral

Be

2

Certification:

Medical

8

31. Date filed (Month, Day, Year) State FEB 29 Registrar

25. Was case referred to medical examiner?

29b. Signature and title of confine

2**XX**N0

5 Pending investigation

6 ☐ Could not be

determined

1 Tes

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

XX Natural

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12070 Old Line Center, Waldorf, MD 20002

2008

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated



DR. ROBERT TIMOTHY PACE

2 ER/Outpatient 3 DOA

28c. Injury at Work?

XXC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0022574

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

Other: 4 Nursing Home XXResidence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2/27/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day BRIZU DAY 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Center Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 X M 2 □ F 51 216-76-3982 October 21, 1956 Washington, D.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll Sykesville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 6655 Sykesville Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 none not applicable 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Perry Dolores Mary Hanis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores M. Perry / Mother #12 Vantage Hill Court, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ebrua 28, 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2008 Bethesda, Maryland 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility. Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Value ovan Due to (or is a consequence of): Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | → Thknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ NO 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 22 No 1. Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Matural Injury 1 ☐ Yes 2 Accident 2 □ No

Examiner The law requires that the death certificate be executed sician and burial-trans Division or Vital Records, P.O. Box 68760, physician the attending ph I for use as the signed to page 2 should Physician: funeral director. this After Hospital or Attending

24 hours after death e Funeral Director: the filled in by

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show at

Director

Funeral

þ

Completed

Be

2

Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

"natural", or items 23a or 28a-f sh edical Examiner must be notified

event, the Medical

permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M

**Physician** /Medical

within 72 hours after

Baltimore, Maryland 21215-0036

within 2 To the

DKLANDO State

3 Suicide

29a. Certifier

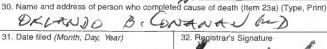
4 ☐ Homicide

(Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

6 Could not be determined





1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                                                                                                                                                                                                                   |                                                                                                                                                                               |                | State of Mary                                                                                                              |                                | artment of H                                                    |                                  | nd Men                            | , 0                          | 0000                            | 0.0001                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------------------------------------------|----------------------------------|-----------------------------------|------------------------------|---------------------------------|------------------------------------|
|                                                                                                                                                                                                                                   |                                                                                                                                                                               |                | Registrar                                                                                                                  | Cei                            | tilicate of t                                                   | Jeam                             | 10.5                              |                              | g. No.                          | 3. Time of Death                   |
| п                                                                                                                                                                                                                                 | Physicia                                                                                                                                                                      | an             | 1. Decedent's Name (First, Middle, Last)                                                                                   |                                | OUTTA                                                           | <b>3.</b> T                      | l N                               | Date of Deatl                | Day Yea                         | r                                  |
|                                                                                                                                                                                                                                   | /Medic                                                                                                                                                                        |                | LARAY                                                                                                                      |                                | QUIN                                                            |                                  |                                   | BRUAR                        |                                 |                                    |
|                                                                                                                                                                                                                                   | Examin                                                                                                                                                                        | er             | 4a. Facility Name (If not institution, give street and number)                                                             | THEFT                          | 4b. City, Town, or                                              |                                  |                                   |                              | 4c. County of De                |                                    |
| 100                                                                                                                                                                                                                               |                                                                                                                                                                               |                | FOREST HILL HEALTH & REHAB C  5. Social Security Number   6. Sex   7. Age (Ir                                              | ENTER  yrs. last birthday)     | If Under 1 Year                                                 | REST H                           | 1 Hrs 8 F                         | Date of Birth                | 9.5                             | FORD  Birthplace (State or Foreign |
| м                                                                                                                                                                                                                                 | Funeral Director                                                                                                                                                              |                | 215-42-0352 1□M 2⊠F 91                                                                                                     | Vro                            | Months Days                                                     |                                  | Min. (                            | Month, Day, 5-07-1           | Year)                           | PA                                 |
|                                                                                                                                                                                                                                   | Pag. 187                                                                                                                                                                      |                | Usual Residence of Decedent                                                                                                |                                |                                                                 |                                  |                                   | 5-07-1                       | 510                             | 111                                |
|                                                                                                                                                                                                                                   | yland<br>yland<br>at                                                                                                                                                          |                | 10a. State 10b. County 10                                                                                                  | c. City, Town or Lo            | cation                                                          |                                  |                                   |                              |                                 | 10d. Inside City Limits            |
|                                                                                                                                                                                                                                   | Mar<br>a-f sh<br>ified                                                                                                                                                        | tor            | MD Baltimore B                                                                                                             | Kingsvill                      | е                                                               |                                  |                                   |                              |                                 | 1 ☐ Yes 2 K No                     |
|                                                                                                                                                                                                                                   | h the<br>or 28;                                                                                                                                                               | Director       | 10e. Street and Number                                                                                                     |                                | 10f. Zip Code                                                   |                                  |                                   | 10                           | 0g. Citizen of What             | Country?                           |
|                                                                                                                                                                                                                                   | th wit                                                                                                                                                                        |                | 12016 Caspian Road                                                                                                         |                                | 21087                                                           |                                  |                                   |                              | USA                             |                                    |
|                                                                                                                                                                                                                                   | ems<br>er mt                                                                                                                                                                  | Funeral        | 11. Marital Status 12. Was Decedent Ever Armed Forces?                                                                     | r in U.S. 13.1                 | Was Decedent of H                                               | ispanic Origii<br>an, Mexican, I | n? (Specify<br>Puerto Rica        | Yes or No-<br>n, etc.)       | 14. Race - Ai<br>Black, W       | merican Indian,<br>hite, etc.      |
| 9                                                                                                                                                                                                                                 | or it                                                                                                                                                                         |                | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No                                                                               |                                | 1 □ Yes 2 No                                                    | Specify:                         |                                   |                              | Specify:                        |                                    |
| 8                                                                                                                                                                                                                                 | 72 hours after death with the Maryland<br>'natural', or items 23a or 28a-f show<br>dical Examiner must be notified at                                                         | d by           | 3 ☑ Widowed 4 ☐ Divorced Year or Dates:                                                                                    | 10- D                          | dantin Hawai Ossus                                              | eties                            |                                   | -                            | T                               | White                              |
| 5                                                                                                                                                                                                                                 | "nat                                                                                                                                                                          | Completed      | 15. Decedent's Education (Specify only highest grade completed)                                                            | (Give                          | dent's Usual Occup<br>kind of work done o<br>DO NOT use retired | ation<br>during most o           | of working                        | 1                            | 16b. Kind of Busine             | ss/moustry                         |
| 12                                                                                                                                                                                                                                | within iene. than "                                                                                                                                                           | ᇍ              | Elementary/Secondary (0-12) College (1-4or 5+)                                                                             | - 1                            | maker                                                           | 7                                |                                   |                              | Own Home                        |                                    |
| d<br>2                                                                                                                                                                                                                            | be filed within 72 hours after death with the Marylan ital Hygiene.<br>ed other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at |                | 17. Father's Name (First, Middle, Last)                                                                                    | 1101110                        |                                                                 | 18. Mother's                     | s Name (Fir                       |                              | Maiden Surname)                 |                                    |
| Maryland 21215-0036                                                                                                                                                                                                               | 2 should be filed w<br>n and Mental Hygie<br>'Is marked other ti<br>raumatic event, th                                                                                        | To Be          | Raymond Kegerise                                                                                                           |                                |                                                                 | Mau                              | de C.                             | Peter                        | 's                              |                                    |
| Z.                                                                                                                                                                                                                                | shou<br>nd M<br>mar                                                                                                                                                           | 1              | 19a. Informant's Name/Relationship (Type. Print)                                                                           | 19b. Mailir                    | ng Address (Street                                              | and Number                       | or Rural Ro                       | oute Number                  | ; City or Town, State           | e, Zip Code)                       |
| ž                                                                                                                                                                                                                                 | alth a 27 is                                                                                                                                                                  |                | Ralph Quinn/Son                                                                                                            | 7820                           | Chapman                                                         | Road                             | Kings                             | sville                       | MD 21087                        |                                    |
| ē,                                                                                                                                                                                                                                | of Hei                                                                                                                                                                        |                | 20a. Method of Disposition                                                                                                 | 20b. Place of Dispo            | sition (Name of<br>matory or other place                        | ce)                              | Date                              |                              | 20c. Location - City            | or Town, State                     |
| Ë                                                                                                                                                                                                                                 | Page<br>nent c<br>nt; if                                                                                                                                                      |                | 1 Bunai 2 Gremation 3 Hemoval from State                                                                                   | Bayview (                      |                                                                 |                                  | 3-01-                             | 2008                         | Baltimore                       | e MD                               |
| Baltimore,                                                                                                                                                                                                                        | permit. Pages 1 and 2 should be<br>Department of Health and Menta<br>Important: If item 27 Is marked<br>any Injury or other traumatic es<br>once.                             |                | 21. Signature of Funeral Service Licensee                                                                                  |                                | 2. Name and Addres                                              |                                  |                                   |                              | Funeral                         | Home Inc.                          |
| m                                                                                                                                                                                                                                 | o a L                                                                                                                                                                         | 10             | Stefaue Knike                                                                                                              | 1                              | 9705 Bela                                                       | ir Rd                            | Nott                              | inghar                       | n MD 2123                       | 6                                  |
| Ε                                                                                                                                                                                                                                 |                                                                                                                                                                               |                | 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. | death. Do not ent              | er the mode of dyin                                             | ig, such as ca                   | ardiac or res                     | spiratory arre               | est,                            | Approximate<br>Interval Between    |
|                                                                                                                                                                                                                                   | Physician<br>/Medical<br>Examiner                                                                                                                                             | î II           | Immediate Cause (Final                                                                                                     |                                |                                                                 |                                  |                                   |                              |                                 |                                    |
| 1                                                                                                                                                                                                                                 |                                                                                                                                                                               |                | disease or condition resulting in death)  Due to (or as a consequence of):                                                 |                                |                                                                 |                                  |                                   |                              |                                 |                                    |
|                                                                                                                                                                                                                                   |                                                                                                                                                                               |                | Sequentially list conditions, b. wend on the transfer of the sequentially list conditions,                                 |                                |                                                                 |                                  |                                   |                              |                                 | 19                                 |
| 7                                                                                                                                                                                                                                 |                                                                                                                                                                               | jue            | if any, leading to immediate cause. Enter underlying Cause (Disease or injury                                              | onsequence of):                |                                                                 |                                  |                                   |                              |                                 | 3                                  |
| if any, leading to immediate cause. Enter uncerying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence *f):  Due to (or as a consequence of):  Due to (or as a consequence of): |                                                                                                                                                                               |                |                                                                                                                            |                                |                                                                 |                                  |                                   |                              |                                 |                                    |
|                                                                                                                                                                                                                                   |                                                                                                                                                                               |                |                                                                                                                            |                                |                                                                 |                                  |                                   |                              |                                 |                                    |
| 687                                                                                                                                                                                                                               | physics the                                                                                                                                                                   | dical          | d                                                                                                                          |                                |                                                                 |                                  |                                   |                              |                                 |                                    |
| ×                                                                                                                                                                                                                                 | leath certific<br>attending p<br>for use as                                                                                                                                   | W/             | IF FEMALE: 23c. If yes, outcome pf p                                                                                       | regnancy                       |                                                                 |                                  |                                   |                              | 23d. Date of                    | delivery                           |
| Вох                                                                                                                                                                                                                               | atter<br>for u                                                                                                                                                                | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □  4 □ Pregnant at tim                                 |                                | ⊒Ectopic pregnancy<br>⊒ Other (specify)                         | /                                |                                   |                              | Month                           | Day Year                           |
| o.                                                                                                                                                                                                                                | that the de<br>led by the a<br>detached t                                                                                                                                     | ıλsi           | 1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown                                                                                       |                                |                                                                 |                                  |                                   |                              |                                 |                                    |
| ₫.                                                                                                                                                                                                                                | requires that<br>een signed by<br>hould be deta                                                                                                                               |                | Part II. Other significant conditions contributing to death but no                                                         | ot resulting in the u          | nderlying cause giv                                             | en in Part I.                    |                                   | 23e. Did tol                 | bacco use contribute            | e to the cause of death?           |
| rg<br>Sp                                                                                                                                                                                                                          | w requires that<br>s been signed t<br>s should be det                                                                                                                         | d by           |                                                                                                                            |                                |                                                                 |                                  |                                   | 1 □ Ye                       | es 2□No 3□                      | Probably 4 Unknown                 |
| 00                                                                                                                                                                                                                                | > 40                                                                                                                                                                          | Completed      |                                                                                                                            |                                |                                                                 |                                  |                                   | 24a. Was a                   | n 24b. Were                     | autopsy findings available         |
| Be                                                                                                                                                                                                                                | 9 L 9                                                                                                                                                                         | mo             |                                                                                                                            |                                |                                                                 |                                  |                                   | autops<br>perform            | med? prior<br>death<br>2 No 1 1 |                                    |
| tal                                                                                                                                                                                                                               | sician: Th<br>certificate<br>rector, pag                                                                                                                                      |                | 25. Was case referred to medical                                                                                           |                                |                                                                 | 26. Place o                      | of Death (C)                      | heck only on                 |                                 | 2 2 3 10                           |
| >                                                                                                                                                                                                                                 | Physician: this certific ral director,                                                                                                                                        | To Be          | examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient                                                                           | 2 ER/Outpatier                 | nt 3 DOA Oth                                                    | er: 4 Nurs                       | sing Home                         | 5 ☐ Reside                   | ence 6 □Other (5                | Specify)                           |
| 0                                                                                                                                                                                                                                 | g Ph<br>ter th                                                                                                                                                                |                | 27. Manner of Death 28a. Date of Injury  (Month, Day Ye                                                                    | 28b. Time o                    | f 28c. Injur<br>Wor                                             | y at<br>k?                       | 28d. Describe how injury occurred |                              |                                 |                                    |
| <u>ö</u>                                                                                                                                                                                                                          | Attending r death. ector: After by the fune                                                                                                                                   | atio           | 2 Accident investigation                                                                                                   | 11,417                         |                                                                 | Yes 2 □ N                        | 0                                 |                              |                                 |                                    |
| Division or Vital Records,                                                                                                                                                                                                        | r Atte<br>er de<br>recto                                                                                                                                                      | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury building, etc. (3               | At home, farm, str<br>Specify) | eet, factory, office                                            |                                  |                                   | Location (St<br>City or Town |                                 | r Rural Route Number,              |
| Q                                                                                                                                                                                                                                 | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral                                            |                |                                                                                                                            |                                |                                                                 |                                  |                                   |                              |                                 |                                    |
|                                                                                                                                                                                                                                   | Hospital<br>14 hours a<br>Funeral I<br>tely filled                                                                                                                            | ical           | 29a. Certifier (Check only  1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of ex                | amination and/or in            |                                                                 |                                  |                                   |                              |                                 |                                    |
|                                                                                                                                                                                                                                   | To the Hospital Within 24 hours a To the Funeral I completely filled                                                                                                          | Medical        | one) and manner stated 29b. Signature and title of certifier                                                               |                                | 29c. Licens                                                     | e number                         |                                   | 2                            | 9d. Date signed (M              | onth. Dav. Year)                   |
|                                                                                                                                                                                                                                   | N N N                                                                                                                                                                         |                | 255. Signature and title of certainer                                                                                      |                                |                                                                 |                                  |                                   |                              |                                 |                                    |
| •                                                                                                                                                                                                                                 |                                                                                                                                                                               |                | - cw 5 3 2)                                                                                                                | /lt 00 \ /=                    |                                                                 | 225                              | 5                                 |                              | 2/26/                           | - 7                                |
|                                                                                                                                                                                                                                   | 6                                                                                                                                                                             |                | 30. Name and address of person who completed cause of death DAVID DUNN - 615 W. MACPHA                                     | i (Item 23a) (Type,<br>IL ROAD |                                                                 | IR, MD                           | ). 21                             | 014                          |                                 |                                    |
|                                                                                                                                                                                                                                   | Sta                                                                                                                                                                           | te_            | 31. Date filed (Month, Day, Year)  32. Pegistrar's                                                                         |                                | DLL A                                                           | للت وحد                          | . 41                              | - T                          |                                 |                                    |
|                                                                                                                                                                                                                                   | Registr                                                                                                                                                                       |                | FEB 2 9 2008                                                                                                               | A A                            | ONE                                                             |                                  |                                   |                              |                                 |                                    |

DHMH 17 Rev 1/2001

Registrar

FEB 2

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2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17.19a per fb 8877.3-26-08vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 26, 2008 **Physician** Alvce Madeline Robinson 4:08 Рм /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson **Baltimore** | Months | Days | Hours | Min. | April 26,1939 | Baltinore, MD. 7. Age (In yrs. last birthday) 68 Yrs. **Funeral** 1 □ M 2 🗓 F 216-34-0092 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No N/A Director Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21239 1224 Walker Ave. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 → Married 1 ☐ Yes 2 ZKNo Specify: ð Specify: White 3 ☐ Widowed 4 ☐ Divorced er than "natura", the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Home Maker Own Home is marked other Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Truman P. Simms Sr. Doris Smith ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rall + i more Maryland 21239 19a. Informant's Name/Relationship (Type. Print) (SOIT) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trae Mr. Robert Philip Robinson, Sr. (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Gard. 20a. Method of Disposition Date 20c. Location - City or Town, State March 01 1 △Burial 2 □ Cremation 3 □ Removal from State 2008 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death Due to or as a consequence of): **Physician** /Medical Examiner Hemodishysis Cathete Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Arten disease 1 🗌 Yes No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has birector, page 2 s autopsy performed? 1 Yes No 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 🔃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066584 2/27/08

State Registrar

31. Date filed (Month, Day, Year)

FEB 2

KOD

DHMH 17 Rev 1/2001

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 105 St. MITESH TRANSADIA, GBMC, Torse, MD. 212

2068

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #7, perFH,g876, 2/29/08 TT Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death - Month **Physician** ebruary 26, 2008 His. County of Death hober /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Months 1 ☐ M 2 💢 F Director 1911110 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Exercise. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 □ No Director Timor 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Race - American Indian, Black, White, etc. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) regori 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2011 19a. Informant's Name/Relationship (Type. Print) (Mephew) 8 ree Lons 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐Removal from State 22. Name and Address of Facility
Joseph L. Russ Fundance
2222 W. North Ave. 21. Signature of Funeral Service Licensee 8:21216 Anniox 23a. Part1. Inter the disease, or complications that caused the shock or heart failule. List only one cause on each line. of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) heart -ongestive **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Roberts page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate | 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) DICE 1 ☐ Yes 27 No 1 Inpatient 2 ER/Outpatient 3 DOA P funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Funeral Director; After To the Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 26,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 Hospice B2 Registrar's Signature (Month, Day, Year) State FEB 2 9 2008 Registrar

DHMH 17 Rev 1/2001

308K/C

9:15

10d. Inside City Limits

Approximate Interval Between Onset and Death

Dav

Baltimore

Year

1 ☐ Yes 2 XNo

A M

ME

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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FEB 29

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

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RM 206

931865

821

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ronald B. Reynolds State of Maryland / Department of Health and Mental Hygiene 2008 06299 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day February 25, 2008 Medical Examiner 1649 hrs Ronald B. Reynolds 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3005 Lavender Avenue Parkville **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Maryland Months Hours Director 217-56-6861 1XXM 2 F 57 02/08/1951 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 28a-f show Essex 1 Yes 2XX No Director 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 1101 "H" Queens Purchase Road 21221 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, permit. Pages I and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Mamied Yes 2 X No 3 Widowed Specify: White 4 XXDivorced If Yes, Give Year Yes 2XX No specify: ò 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 Mechanic Boat Yard 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Sumame) James W. Reynolds <u>Lorretta Mae Wheatley</u> 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen E. Scholing - Ex Wife 2313 Bauernschmidt Drive, Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 XXCremation 3 Bayview Crematory Inc 02/29/2008 Baltimore, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 2) Signature of Funeral Service Licenses 1407 Old <u>Eastern Avenue, Essex, Maryland 2122</u>1 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical physician a X UNPENDED #Z3a.PII.27.perME.g877, 3/4/08 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the ned by the attending detached for use as t Live birth Ectopic pregnancy Fetal death Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Right inguinal hernia Completed director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? certificate ✓ Yes 2 ✓ Yes 2 No To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifit completely filled in by the funeral director, I 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ၉ 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Pending Yes 2 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) Homicide 29a. Certifier 1 ical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mod O.C.M.E. February 26, 2008 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar DHMH 17 Rev 1/2001 OCME 2006

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend Item 4c & 24a 2/29/08 dnk Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 530, **Physician** 126,200 8 /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) Examiner WERLEA MURSING Home Year If Under 24 Hrs. Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M M Months Days 216-07-6499 October 8,1909 Director mi Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic event. 10c. City, Town or Location 10b. County 10d. Inside City Limits Yes 2 No Funeral Director BAITI MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21200 U.S.A 6116 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify: B/AUK þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 89RAde None leaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EAST ORANGE AIG. 20b. Place of Disposition (Name of cemetery, crematory or other place) RENdA 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State HABINTAL 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxima e Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) by the a Division or Vital Records, P.O. 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has le 2 s autopsy performed After this certificate 2. No To the Hospital or Attending Physician: rector. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 일 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 12 Accident 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of Pertifier 29c. License number 29d. Date signed (Month, Day, Year) ver Blud Baltimore 40 21239 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32. Registrar's Signature FEB 2 2008 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bauhner Ma If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Worth, Day, Birthplace (State or Foreign Country) 6. Sex 7 Age (In yrs. last birthday) **Funeral** Months 1□ M 2□€ Director Usual Residence of Dec Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No r 28a-f sh notified Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural", or items 23a or dical Examiner πust be r ISA Funeral Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes Q No Specify: þ 3 ☐ Widowed 4 ☐ Norced Completed 16a Decedent's Usual Occupation ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Prin Health tem 27 Manchester ND 21102 sanann 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Important: If its any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 129/2008 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylpd, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ASCVD | natural courses /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 2 □ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 22 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 🔲 Inpatient 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury **Natural** 5 Pending investigation М n 24 hours after death. he Funeral Director: A pletely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Tipic ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063347 MRIES MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MNOSS Kenjar 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 16:19 M SUMMONS 02 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CIT BALTIMORB MO J.H. DAY VIEW If Under 1 Year | If Under 24 Hrs. Z-Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** 219-26-594 Days Hours 4 6 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at MD BALTIMORE 1 Tes 2 No MO Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n 21206 15/A ST REGIS Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

wit; If tem 27 is marked other than 'natural', or items 23: my; or other traumatic event, the Medical Examiner must any or other traumatic event, the Medical Examiner must 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: DCACK þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) John Hopkins Medical Tech 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be Ben Westmorland illian Gri 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harford A Baltimore MD 2214

ion (Name of Date 20c. Location - City or Town, State smoons 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 13/2008 Baltimore MI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice lough C. Greeno, Funeral Services Saffemore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC Physician BARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** YEARS SCVID Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by BESIT Y 3 ☐ Probably 4 ☐ Onknown 1 TYes 2 □ No LUNG DISENSE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ROWIC 24a. Was an autopsy performed Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation n 24 hours after death.

te Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

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completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signatule and title of certific 29d. Date signed (Month, Day, Year) 3540 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ER

State Registrar

DHIME 17 HeV 1/2001

FEB 2 9 2008

NOK

31. Date filed (Month, Day, Year)

I.H.BAYVEEN 32. Registrar's Signature

DALTIMONE MU 21124

Division or Vital Records, P.O. MILTON SMITH

3:30

this certificate Be P Certification:

To the Funeral Director: After completely filled in by the funer To the Hospital within 24 hours

State Registrar

Medical

1 ☐ Yes 2 X No 27. Manner of Death 1X Natural 5 ☐ Pending investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

examiner?

29a. Certifier

(Check only one)

6 Could not be determined

FEB 2

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 28c. Injury at Work? 1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my state of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause o

28d. Describe how injury occurred

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d, Date signed (Month, Day, Year) 08

HOSPICE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Feb. 8:45 DM **Physician** Annie /Medical 4b. City, Town 4a. Facility Name (If not institution, give street and number 4c. County of Dea or Location of Death **Examiner** Baltimore Future Care Homewood If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 M 2 F torth Carolina 240-38-6590 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f ehow amy injury or other traumatic event, it is Madical Examinational Demolified a one. 1 Yes 2 □ No laryland Director 10g. Citizen of What Country? 10e. Street and Number Chesterfi Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Custodian 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Schools 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dorothy Goodwin 19a. Informant's Name/Relatio ship (Type, Print) Jones - daughter Battimore 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician Tou /Medical Due to (or as a cons quence of): **Examiner** ten Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last 0 Due to for as a consequence of) Examiner tten ing physician and or u e as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No s after death.

al Director: After this certifica
ed in by the funeral director, p 26. Place of Beath (Check only one) 25. Was case referred to medical examiner?

1 \( \sum \) Yes \( 2 \sum \) No To Be Other: 4 virsing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: Injury 1 Matural 5 Pendina investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 🔽 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

5

30. Name and address of person

BARSHAN.

32 Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

1600 W. MOUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Day 7:30 a Hazel Slaughter Feb 24, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A **Baltimore** 1621 Kingsway Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 ☐ M 2 ☑ Months No. Carolina 92 Jan 23, 1916 053-16-6053 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TXYes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1621 Kingsway Road 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican. etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify. Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shoe Factory Sewing Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ivey Jackson Willie Freeman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1621 Kingsway Road Baltimore, Maryland 21218 Marlene Epps 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 03/01/08 Lansdowne, Maryland 4 □ Donation 5 □ Other (Specify) Mt. Zion Cemetery of Funeral Se 22. Name and Address of Facility Estep Brothers Funeral Service, 1 1300 Eutaw Place Baltimore, Md. Part1. Enter the disease shock, or heart failure. I e, or complications that caused List only one cause on each lii ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 22 disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Month

Year

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

Examiner must be notified

event, the Medical

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Injury

Directo

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

/Medical

Examiner attending physician a for use as the burial-Physician/Medical as by the a signed by Completed by has certificate ha: rector, page 2 director To Be this Medical Certification: within 24 hours arret useum.

To the Funeral Director: Af

The law requires that the death certificate be executed

or Attending Physician:

Divigion or Vital Records, P.O. Box 68760,

IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 5 ☐ Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 24a. Was an autopsy performe 1∐ Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 🔲 Yes  $2\Box$ 1 Inpatient 2 □ ER/Outpatient 3 □ DOA € Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mannef of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifie

FEB29

100 Registrar's Signature 31. Date filed (Month, Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2/28/08 Year **Physician** William E. Smith 12:20pm <sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charlotte Hall Veterans Home Charlotte Hall, MD Saint Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Numbe 065-10-8495 Age (In yrs. last birthday) 93 Yrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**XX**M/ 2□ F Director 6/22/1914 MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f ehow the Medical Examiner must be notified at Calvert Lusbey MD 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 20657 USA 289 Overlooke Drive Iteme 23a Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
12 Yes 2 No
If Yes, Give Wås Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Army filed within 72 hours after 1 Never Married 2 Married white ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WWII Specify Completed by 3 ₩idowed 4 Divorced Year or Dates 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk Steel 0 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liqury or other treumatic event once. Be Annie Herline Edward Smith 2 19a. Informant's Name/Relationship (Type, Print)

JAmes A. Smith / Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 289 Overlook Drine, Lusby MD 20657 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Holy Cross Cemetery ©Burial 2 ☐ Cremation 3 ☐ Removal from State March 3, 2008 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Function Service Local See Victor P. Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Naso **Physician** O nari /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the buriat-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed nis certificate hes been si I director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) ASS tSS 1 ☐ Yes 2 🛣 No ဥ 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ţ, 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)
EB 2 9 2008

Alikhow

30. Name and address of person who completed cause " teath (Itam 22a) ype, Print



MMY

46046

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>25 2008 **Physician** FEBRUARY SIEGEL 10:15P M HAROLD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE TIMONIUM STELLA MARIS HOSPICE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 10/03/1935 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 72 MD 213-32-1458 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 HIGH STEPPER COURT, #304 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Ves 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) PHARMACIST PHARMACY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **SCHULMAN** 2 SYLVAN SIEGEL EVA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 HIGH STEPPER COURT, #304, PIKESVILLE, MD HARRIET SIEGEL / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW REISTERSTOWN, MD 02/28/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Juneral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructive Physician Chromic /Medical Due to (or as a consequence of): **Examiner** Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vnknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 207 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certification: Attending 5 Pending investigation 1 🖪 Katural To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗷 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 Registrar 2008 9

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Trice 0 2008 /ava /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Citz Mercn Medical Baltimore MD 5. Social Security Number yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Year) 1 M 2 K 30 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 7es 2 No Director timore 10g. Citizen of What Country? 10e. Street and Number USA by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married r than "natural", or the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z 19a. Informant's Name/Relationship (Type permit. Pages 1 and 2:
Department of Health as
Important: If item 27 Is
any injury or other trau MU 2/239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) robable /Medical Due to (or as a consequence of) Examiner Sequentially, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4⊡Pregnant at time of death 5 Other (specify) ed by the a detached f ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4XiUnknown 2 No 3 Probably 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one, 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient R/Outpatient 3 DOA ို this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Marmer of Death 28a. Date of Injury 8b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year)

State Registrar St Paul

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

D006340

Baltimore

08-01585 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 06309 State of Maryland / Department of Health and Mental Hygiene John Joseph Tormollan 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Time of Death Physician/ Month Day February 24, 2008 1129 hrs **Medical Examiner** John Joseph Tormollan 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Middle River 803 Bowleys Quarters Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreian Months Davs Hours Director 12.07.1961 Country) 1 M 2 F 46 215.74.3512 Yrs Usual Residence of Decedent 10d, Inside City Limits 10c. City. Town or Location 10a, State 10b. County 1 Yes 2 No Middle River MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number U.S.A. 803 Bowleys Quarters Road unknown Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Yes White 4 Divorced Yes 2 No specify: Specify: If Yes, Give Year Widowed 2 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ within 72 Health and Mental Hygiene. item 27 is marked other than " r traumatic event, the Medical Baltimore, MD 21215-0036 B.&W. Fabrication Welder 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) If item 27 is marked her traumatic event, Otts Tormollan Mary Wooden Joseph Farl Tormollan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print 412 Walcott Road, Baltimore, MD 21206 Joshua Tormollan/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. of I 02.27.08 Beltsville, MD rtant: Donation 5 Other Specify: è 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21. Signature of Funeral Service Licensee MO1446 8717 Green Pastures Dr. Balto., 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Heroin intoxication and alcohol use Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical #E. perlH, 08// 3///08 TT #Za,27,28a-f, perME,g877 3/6/08 TT X UNPENDED attending physician or use as the burial death certificate be Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death Other (Specify 1 Yes 2 No 9 Unknown 9 Unknown the requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? . death? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital or Attending Physician: Be Other<sub>4</sub> examiner? lospital: Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes ဥ 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural Yes 2X No within 24 hours after death.

To the Funeral Director: completely filled in by the fi Pending unk Fnd 2/24/2008 | Fnd 11:24 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide or Town, State) MD 803 Bowleys Quarters Rd. Middle River. determined the Hospital (Specify) found at home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe February 25, 2008 O.C.M.E. rvv Incenti MID 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 31. Date filed (Month, Ley B'ear) 32. Registrar's Signature 200 State 9 Registra

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5 08 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ar Mary lano Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign Months Hours 231-66 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner muses became once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Pres 2 No Funeral Director Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 256 Heuderson <u>24210</u> Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status Black, White, etc. ☐Yes 2 Yes, Give 2 140 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Year or Dates: Whit Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Georgia Humphrey ? ျ <u>Marmon Wise</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 256 Henderson Court Abingdon VA 24210

Date 20c. Location - City or Town, State Anita Wise 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 2.29.2008 Abjugdon, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, All promoditions of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the cour Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lena /Medical Due to ? r as a consequence of) **Examiner** Ster Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 certificate ha dos 1☐ Yes 1 ☐ Yes 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 🗸 🗸 🗸 🗸 1 🖸 2 1 🔲 Inpatient 2MER/Outpatient 3 □ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide vithin 24 hours after To the Funeral Dir 🗠 🔾 🔾 Earlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed c use of death (Item 23a) (Type, Print) bert 31. Date filed (Month, Day, Year) gistrar's Signature 32. R State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 8:00 PM **Physician** 23 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner hion Memoria altimore Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 213-36-7616 MDirector Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yee 2 ☐ No Paltimore **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Kernwood *ରାରାର* Race - American Indian. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2 ☐ No þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Sanitation 12+1 Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be dmund 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) er 311 Cherry Chape Ind Reisterstam, MD 21136

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State Kurek Arlene /Laughter 20a. Method of Disposition 1 ☐ Buria! 2 ☐ Cremation 3 ☐Removal from State irbutus Memorial 2/29/2008 Baltimore, MI) 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Service 4905 York And Baltimore, MD 21212 21. Signature of Funeral Service Licenses reene 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SPIRATORY UNUNOWN /Medical Due to (or as a consequence of) Examiner METASTATIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2₩ No 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 WNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT2438946 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNJON MEMORIAL HOSPITAL, 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician February 24, 2008 49 County of Death YVZY /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BelAIR upper Chesapeake 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠**M 2□F Days 84 Yrs. Baltimore, mo Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No **Funeral Director** orest HII Har 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21050 USA 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Ves 2 No
If Yes, Give
Year or Dates: N C V 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) C+P Telephone Co. Engineer Assistant La 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hnna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hi11 Forest Hill mp 21050 A. ousan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date -38-08 1 Burial 2 □ Cremation 3 □ Removal from State Belair, mo Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/Liceny 22. Name and Address of Facility Evans Funeral Chapel-Bel Ar 3 Newport Dr. Forst Hill 23a. P. nt. Enter the disease, or or flication, the caused the deal. Do not enter the mode dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Lung Immediate Cause (Final year **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Month Year in the past 12 months? Day 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death

1 Natural

2 □ Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Let Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifie Type, Print)
Upper Chesapeake Bel Air, Md. 2/014 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Kevin MA 31. Date filed (Month, Day, 32. Registrer's Signature State 2008 ▶ Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Februar 124,2008 Michael /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA 33N. AS948 BAHIMON If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 180 M 2□ F **Director** 216-50-42 Novamber 8, 1949 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No Director MID BAIT. MOre 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code a or 21200 U.S.A 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: BIACK 2 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) SAN. TATION WORKS Unknown un Know 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WAKNOWA WIKMOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 DAMON BAHTOMD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03-1-08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility alrie HOGN PAROLINEST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Security is conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Linknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 🐧 No 3 Probably 4 ☐Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page certificate 1□ Yes or Vital 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home Hospital: 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) မှ 1 Inpatient Director: After this in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division the Hospital or Attending 5 Pending investigation Injury 1 Natural 1 □ Yes 2 □ No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after To unc... within 24 hours are... To the Funeral Dir --totely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37049 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

100/

MD

TOTAL

32. Registrar Signature

2005

Cathedral St,

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

Medical

Sara M. Handy, 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

University of Maryland Medical Contes, 22 S. Greene St., Baltimore, MD, 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



(Check only one)

29c. License number

17418

29d. Date signed (Month, Day, Year)

Feb. 26,2008

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                |                  | _ For                                                                                                       | State of Maryland                                                    | d / Departm                              | ent of He                        | ealth and I                            | Mental H                        | ygiene                        |                                                     |                                                    |
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| Physi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | iciar          |                  | Decedent's Name (First, Middle, Last)                                                                       |                                                                      |                                          |                                  |                                        | 2. Date of Month                | Death<br>Day                  | Year                                                | 3. Time of Death                                   |
| /Me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | dica           | Ļ.               | Bernard                                                                                                     |                                                                      | iams                                     | City Town or I                   | Location of Death                      | 1 2                             | 24                            | 200 \$                                              | 7972M                                              |
| Exam                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | nine           |                  | 4a. Facility Name (If not institution, give s                                                               | 1 . 1. 1 .                                                           |                                          |                                  | more:                                  |                                 | 40.                           | NIA                                                 |                                                    |
| Funera                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | al             |                  | 5. Social Security Number 6. Sex                                                                            | 7. Age (In yrs. Ia                                                   | ast birthday) If U                       | nder 1 Year                      | If Under 24 Hrs.<br>Hours Min.         | 8. Date of I                    | Birth<br>Day, Year)           | 9. Birthp                                           | lace (State or Foreign                             |
| Directo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                |                  | unk                                                                                                         | M 2 F 20                                                             | Yrs.                                     | uis Days                         | Tiours Will.                           | Aug. S                          | 21,198                        | 7 Ma                                                | ryland                                             |
| and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | // T           | -                | Usual Residence of Decedent  10a. State 10b. County                                                         | 10c. City,                                                           | Town or Location                         |                                  |                                        |                                 |                               | 1                                                   | 0d. Inside City Limits                             |
| Maryl<br>f sho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3              | 5                | Md N/A                                                                                                      | $\mathcal{P}$                                                        | altim                                    | 010                              |                                        |                                 |                               |                                                     | 1 Yes 2 No                                         |
| h the<br>rr 28a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | ב                | 10e. Street and Number                                                                                      |                                                                      |                                          | . Zip Code                       |                                        |                                 | 10g. Citiz                    | zen of What Coun                                    | itry?                                              |
| th wit<br>23a o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1 2            | ਰ<br>ਹ           | 1726 Langfo                                                                                                 | rd Rd.                                                               |                                          | 2121                             | 07                                     |                                 |                               | USA                                                 |                                                    |
| er dea<br>tems                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                |                  | 11. Marital Status                                                                                          | 12. Was Decedent Ever in U.S<br>Armed Forces?                        |                                          | ecedent of His<br>specify Cubar  | spanic Origin? (S<br>n, Mexican, Puert | pecify Yes or<br>o Rican, etc.) | No-                           | <ol> <li>Race - Americ<br/>Black, White,</li> </ol> |                                                    |
| rs afte                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Į ū            | Dy L             | 1 Never Married 2 Married<br>3 Widowed 4 Divorced                                                           | 1  Yes 2 M No<br>If Yes, Give<br>Year or Dates:                      | 1 □ Y€                                   | es 2XINo                         | Specify:                               |                                 |                               | Specify: D                                          | anv                                                |
| 2 hou                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 3              | 2                | 15. Decedent's Educ                                                                                         | cation                                                               | 16a. Decedent's                          |                                  |                                        |                                 | 16b. Kir                      | nd of Business/Inc                                  | dustry                                             |
| thin 7;<br>e. an "n<br>Medi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Total and      | 1                | (Specify only highest grade<br>Elementary/Secondary (0-12)                                                  | completed) College (1-4or 5+)                                        | (Give kind o<br>life. DO NO              | f work done di<br>T use retired) | uring most of wor                      | king                            | 1                             | 1//1                                                |                                                    |
| ed wit<br>ygien<br>t, the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ٤              | 5 -              | 9                                                                                                           |                                                                      | une                                      | empl                             | oyed                                   |                                 |                               | NJA                                                 |                                                    |
| be fill had out                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | á              | Ď -              | 17. Father's Name (First, Middle, Last)                                                                     | 11/: 11:00                                                           |                                          | '                                | 18. Mother's Nan                       | ne (FIFST, IMIAC                | aie, maiden<br>L              | Lac La                                              | _                                                  |
| it yie<br>should<br>id Me<br>mark<br>matic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | F              | 2                | 19a. Informant's Name/Relationship (Ty)                                                                     |                                                                      | 19b. Mailing Add                         | ress (Street a                   | nd Number or Ru                        | iral Route Nui                  | nber, City o                  | Town, State, Zip                                    | Code)                                              |
| nd 2 salth ar 27 is                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                |                  | Mslokiesha                                                                                                  | Lowery                                                               | 1726                                     | Lanat                            | Gord 7                                 | Pd. P                           | alto                          | Md 2                                                | 1207                                               |
| ges 1 and 2 should be filled within 72 hours after death with the Marylan ges 1 and 2 should be filled within 72 hours after death with the Marylan it of Health and Mentall Hygiene. The fire 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                |                  | 20a. Method of Disposition                                                                                  | √20b. Pla                                                            | ace of Disposition<br>emetery, crematory | (Name of )<br>or other place     | 3/4/2                                  | 108<br>Date                     | 20c. Lo                       | cation - City or To                                 | own, State                                         |
| Page<br>Page<br>ant: If                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                |                  | 1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ R<br>4 ☐ Donation 5 ☐ Other ( <i>Specify</i> )                          | removal from State                                                   | enMoun                                   | t Gene                           | ctory 3/                               | 3/2008                          | B                             | ulto, M                                             | d.                                                 |
| portition of signal of a local product of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many interest of the many | once.          |                  | 21. Signature of Funeral Service License                                                                    | <b>V W</b>                                                           | J05e                                     | e and Address                    | s of Facility                          | -<br>1100 C/                    | 1 Ho                          | me, P.A.                                            |                                                    |
| 007.0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | OI             | 1                | youph o                                                                                                     | X. Russ                                                              | 2222                                     | WINC                             | FAK AV                                 | 2. Bai                          | to, M.                        | d. 21210                                            |                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | J                | 23a. Part / Enter the rease, or complished, or heart f flure. List only or Immediate Cause (Final           | ne cause on each line.                                               | . Do not enter the                       | mode of dying                    | j, such as cardial                     | or respirator                   | y arrest,                     |                                                     | Approximate<br>Interval Between<br>Onset and Death |
| Physicia<br>/Medica                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | _              |                  | disease or condition resulting in death)                                                                    | Due to (or as a consequence                                          |                                          |                                  |                                        |                                 |                               |                                                     |                                                    |
| Examine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | er             | 1                |                                                                                                             | 540 10 (0) 40 4 00110044                                             | 0.100 0.7.                               |                                  |                                        |                                 |                               |                                                     |                                                    |
| P #                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | i i            | פֿ               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequent                                           | ence of):                                | -                                |                                        |                                 |                               |                                                     |                                                    |
| ecute<br>and<br>trans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                | 2                | Cause (Disease or injury that initiated events resulting in death) Last                                     | Due to (or as a consequ                                              | anna of).                                |                                  |                                        |                                 |                               |                                                     |                                                    |
| or ou, cate be executed obysician and the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ú              | 2                | a saming in additing and                                                                                    | Due to (or as a conseque                                             | ence or).                                |                                  |                                        |                                 |                               |                                                     |                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | laciba         | 2                | C                                                                                                           | l                                                                    |                                          |                                  |                                        |                                 |                               |                                                     |                                                    |
| To the Hospital or Attending Physician: The law requires that the death certification in the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | M/M.           | riiyəlcidii/ivic | !F FEMALE: 23b. Was decedent pregnant 2                                                                     | 3c. If yes, outcome pf pregnar                                       |                                          |                                  |                                        |                                 | 2                             | 23d. Date of delive                                 | ery                                                |
| death<br>death<br>e atte                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1.5            | 2                | in the past 12 months?<br>1 ☐ Yes 2 ☐ No                                                                    | 1 □Live birth 2 □ Fetal<br>4 □ Pregnant at time of de<br>9 □ Unknown |                                          | r (specify)                      | <del></del>                            |                                 | -                             | Month                                               | Day Year                                           |
| at the<br>by th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1              | <u> </u>         | 9 Unknown                                                                                                   |                                                                      |                                          |                                  |                                        | 00. 5                           |                               |                                                     | he cause of death?                                 |
| res th<br>signed<br>be de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                |                  | Part II. Other significant conditions cor                                                                   | -                                                                    | Iting in the underlyi                    | ng cause give                    | n in Part I.                           |                                 |                               | se contribute to ti                                 |                                                    |
| requires to seen signe should be of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 100            | מוכח             | Human immune                                                                                                | deficiency                                                           |                                          |                                  |                                        |                                 |                               |                                                     |                                                    |
| has by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 100            | combiered by     | Diventricular h                                                                                             | eart failur                                                          | ح                                        |                                  |                                        | 24a. W<br>au                    | ras an<br>utopsy<br>erformed? | death?                                              | ppsy findings available<br>mpletion of cause of    |
| ifficate<br>or, par                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                |                  | 5665.5<br>25. Was case referred to medical                                                                  |                                                                      |                                          |                                  | 26. Place of Dea                       | 1□ Ye                           |                               | 1 ☐ Yes                                             | 2 □ No                                             |
| ysicia<br>ysicia<br>s cert                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | G C F          |                  | examiner?                                                                                                   | Hospital: 1 ☐ Impatient 2 ☐ E                                        | ER/Outpatient 3                          | DOA Othe                         |                                        |                                 |                               | 3 □Other (Specil                                    | (v)                                                |
| g Ph<br>ter thi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                |                  | 27. Manner of Death 1 Manual 5 ☐ Pending                                                                    | 28a. Date of Injury<br>(Month, Day Year)                             | 28b. Time of<br>Injury                   | 28c. Injury<br>Work              |                                        | 28d. Descril                    |                               |                                                     |                                                    |
| eath.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1              | מוני             | 2 ☐ Accident investigation                                                                                  |                                                                      | М                                        | 1 🗆 Y                            | /es 2□No                               |                                 |                               |                                                     |                                                    |
| or Att                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Cottooliitoo   |                  | 3 ☐ Suicide 6 ☐ Could not be determined                                                                     | 28e. Place of injury - At hor building, etc. (Specify)               | me, farm, street, fa<br>)                | ctory, office                    |                                        | 28f. Locatio<br>City or         | n (Street an<br>Town, State   | d Number or Run<br>)                                | al Route Number,                                   |
| pital<br>curs a<br>eral I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                |                  | 29a. Certifier 1 Certifying Phys                                                                            | slcian: To the best of my know                                       | vledge, death occu                       | rred at the tim                  | ne, date and place                     | e, and due to t                 | the cause(s)                  | and manner as s                                     | stated.                                            |
| e Hos<br>24 h<br>e Fun<br>letely                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 100            | Medical          |                                                                                                             | ner: On the basis of examinati<br>and manner stated.                 |                                          |                                  |                                        |                                 |                               |                                                     |                                                    |
| To th<br>Within<br>To th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | N.             | <u> </u>         | 29b. Signature and title of certifier                                                                       |                                                                      |                                          | 29c. License                     | number                                 |                                 | 29d. Dat                      | e signed (Month,                                    | Day, Year)                                         |
| 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                |                  | > Mun                                                                                                       | MD                                                                   |                                          | P-2                              | 1195                                   |                                 | 2/2                           | 14/08                                               |                                                    |
| 1-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                | 1                | 30. Name and address of person who co                                                                       |                                                                      |                                          |                                  |                                        |                                 | •                             |                                                     |                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                |                  | Joseph Has 22 31. Date filed (Month, Day, Year)                                                             | 5. Greene St.                                                        | Baltime                                  | T, M                             | 1) 2120                                |                                 |                               |                                                     |                                                    |
| Regi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | State<br>istra |                  | FEB 2 9 20                                                                                                  | 32. egistrar's Signat                                                | & Sugar                                  | 80                               |                                        |                                 |                               |                                                     |                                                    |
| DHMH 17 Rev                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1/200          | 1                |                                                                                                             | July V                                                               | 1                                        |                                  |                                        | · ·                             |                               |                                                     |                                                    |

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|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------|----------------------------|-----------------------------------------------------|--|
| F        | Physicia                                                                                                                                                                                                                                                                                                                           | an                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                | 2. Date of Death<br>Month             | Day Ye                     | 3. Time of Death                                    |  |
|          | /Medic                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                 | Aubrey Willis Williams Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | Februar                               |                            | 008 10:00 AMM                                       |  |
|          | Examin                                                                                                                                                                                                                                                                                                                             | er                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4b. City, Town, or Location of Death                                           |                                       | 4c. County of Death        |                                                     |  |
|          |                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                 | Washington Adventist Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Takoma Pa                                                                      | ark<br>8. Date of Birth               |                            |                                                     |  |
| + ,      | Funeral<br>Director                                                                                                                                                                                                                                                                                                                |                                                                                                                                                 | 230-14-3984 Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Months Days Hours Min.                                                         | (Month, Day, Y                        | ear)                       | Birthplace (State or Foreign Country)               |  |
|          | s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at                                                                                            | 'n                                                                                                                                              | 10a. State 10b. County 10c. City, Town or L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ocation                                                                        |                                       |                            | 10d. Inside City Limits 1 ☐ Yes 2 📆 No              |  |
|          | Ba-f:                                                                                                                                                                                                                                                                                                                              | Director                                                                                                                                        | MD Montgomery Silver S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | 140                                   | 0:::                       |                                                     |  |
|          | vith th                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                 | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10f. Zip Code                                                                  |                                       | g. Citizen of Wha          |                                                     |  |
|          | s 23                                                                                                                                                                                                                                                                                                                               | Funeral                                                                                                                                         | 205 Hartwell Rd.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 20901-                                                                         |                                       | Jnited S                   | American Indian,                                    |  |
|          | ter de<br>item<br>ner r                                                                                                                                                                                                                                                                                                            | ü                                                                                                                                               | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 ☑ Yes 2 □ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Was Decedent of Hispanic Origin? (Sp<br>If Yes, specify Cuban, Mexican, Puerto | Rican, etc.)                          |                            | White, etc.                                         |  |
| 2        | rs aff                                                                                                                                                                                                                                                                                                                             | by F                                                                                                                                            | 3 ☐ Widowed 4 ☑ Divorced Year or Dates: WW ፲                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1 ☑ Yes 2 ☐ No Specify:  Mexican                                               |                                       | Specify:                   | White                                               |  |
| 5        | 2 hou<br>atura<br>cal E                                                                                                                                                                                                                                                                                                            |                                                                                                                                                 | 15 Decedent's Education 16a. Dece                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | edent's Usual Occupation                                                       | 116                                   | Bb. Kind of Busin          | ess/Industry                                        |  |
| 2        | nin 72<br>In "nin<br>Medij                                                                                                                                                                                                                                                                                                         | ple                                                                                                                                             | (Specify only highest grade completed) (Given life.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | e kind of work done during most of work<br>DO NOT use retired)                 | king 1                                | Higher E                   | Education                                           |  |
| 7        | d with                                                                                                                                                                                                                                                                                                                             | Completed                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | essor of Anthropo                                                              | logy                                  |                            |                                                     |  |
| 2        | al Hy<br>l othe                                                                                                                                                                                                                                                                                                                    | Be                                                                                                                                              | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 18. Mother's Nam                                                               | e (First, Middle, Ma                  | aiden Surname)             |                                                     |  |
| N D      | Ment<br>Ment<br>arked<br>atic e                                                                                                                                                                                                                                                                                                    | 인                                                                                                                                               | Aubrey Willis Williams Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Anita Cl                                                                       | harlotte S                            | chreck                     |                                                     |  |
| 0        | 2 sho<br>and<br>is ma                                                                                                                                                                                                                                                                                                              |                                                                                                                                                 | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ing Address (Street and Number or Ru                                           |                                       | -                          |                                                     |  |
| 2,2      | 1 and 2<br>Health<br>tem 27 i                                                                                                                                                                                                                                                                                                      |                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4 Modoc Rd. Santa                                                              |                                       |                            |                                                     |  |
| 5        | ges 1<br>t of H<br>if ite                                                                                                                                                                                                                                                                                                          |                                                                                                                                                 | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | Feb 27                                | Oc. Location - City        |                                                     |  |
|          | Factorial fundamental                                                                                                                                                                                                                                                                                                              |                                                                                                                                                 | 4 □ Donation 5 □ Other (Specify) Chesape                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ake Crematory                                                                  | 2008                                  | Beltsvill                  | le, Maryland                                        |  |
| מם       | permit. Pages 1 and 2<br>Department of Health a<br>Important: If Item 27 is<br>any Injury or other tra<br>once.                                                                                                                                                                                                                    |                                                                                                                                                 | 21. Signature of Funeral Service Licensee MU0382                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 2. Name and Address of Facility  Rapp Funeral & Crem.  933 Gist Ave. Silve     | ation Serv<br>er Spring,              | ices<br>Marylan            | d 20910-                                            |  |
|          |                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                 | 23a. Part1. Ent r the disease, or complications that sused the death. Do not en shock, or heart failure. List only one cause on pacture.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                       |                            | Approximate<br>Interval Between                     |  |
|          | Physician                                                                                                                                                                                                                                                                                                                          | iner                                                                                                                                            | Immediate Cause (Final disease or condition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | umerralu                                                                       | Wille.                                | 0                          | Onset and Death                                     |  |
|          | /Medical                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                 | resulting in death)  Due to (or as a posequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | A- 1                                                                           | COVUC                                 | <b>*</b>                   |                                                     |  |
|          | Examiner                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                 | Sequentially list conditions, b.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | was whele                                                                      | monu                                  | l                          |                                                     |  |
|          | D #5                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                 | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | -                                                                              |                                       |                            |                                                     |  |
| 1        | ecute<br>and<br>trans                                                                                                                                                                                                                                                                                                              | Examiner                                                                                                                                        | Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                       |                            |                                                     |  |
| Š,       | be ex                                                                                                                                                                                                                                                                                                                              | E E                                                                                                                                             | Due to (or as a consequence or).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                       |                            |                                                     |  |
| 0        | icate be executed<br>physician and<br>s the burial-transit                                                                                                                                                                                                                                                                         | edical                                                                                                                                          | d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                       |                            |                                                     |  |
| <u> </u> | certific<br>iding p                                                                                                                                                                                                                                                                                                                | /Me                                                                                                                                             | IF FEMALE: 23c. If yes, outcome pf pregnancy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                       | 23d. Date o                | of delivery                                         |  |
| מ        | attendin<br>for use                                                                                                                                                                                                                                                                                                                | cian                                                                                                                                            | in the past 12 months?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | □Ectopic pregnancy<br>□ Other <i>(specify)</i>                                 |                                       | Month                      |                                                     |  |
| į        | the d<br>y the                                                                                                                                                                                                                                                                                                                     | Physician/M                                                                                                                                     | 1 Yes 2 No 9 Unknown 9 Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                |                                       |                            |                                                     |  |
| ř.       | w requires that the de<br>been signed by the<br>should be detached                                                                                                                                                                                                                                                                 |                                                                                                                                                 | Part II. Other significant conditions contributing to death but not resulting in the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | underlying cause given in Part I.                                              | 23e. Did toba                         | icco use contribu          | ute to the cause of death?                          |  |
| 25       | quires<br>n sign<br>ald be                                                                                                                                                                                                                                                                                                         | d by                                                                                                                                            | Small bould ome                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | malen                                                                          | 1 ☐ Yes                               | 2 □ No 3[                  | ☐ Probably 4 ☑ Unknown                              |  |
| 5        | s bee                                                                                                                                                                                                                                                                                                                              | lete                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | 24a. Was an                           | , 24b. We                  | re autopsy findings available                       |  |
| 5        | The la                                                                                                                                                                                                                                                                                                                             | Completed                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | autopsy<br>perform<br>1∐ Yes 2        | ed7 dea                    | or to completion of cause of<br>ath?<br>IYes 2 □ No |  |
| g        | sician: The lav<br>certificate has<br>rector, page 2                                                                                                                                                                                                                                                                               | (D)                                                                                                                                             | 25. Was case referred to medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 26. Place of Dea                                                               | th (Check only one)                   |                            |                                                     |  |
| >        | ysici<br>is cer<br>direc                                                                                                                                                                                                                                                                                                           | o.                                                                                                                                              | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ent 3 DOA Other: 4 Nursing H                                                   | ome 5□Residen                         | nce 6 □Other               | (Specify)                                           |  |
| 2        | ng Ph<br>ter th<br>neral                                                                                                                                                                                                                                                                                                           | T:u                                                                                                                                             | 27. May er of Death 1 Natural 5 □ Pending (Month, Day Year) 28b. Time Injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | of 28c. Injury at Work?                                                        | 28d. Describe hov                     | v injury occurred          |                                                     |  |
| 5        | endir<br>ath.<br>or: Af                                                                                                                                                                                                                                                                                                            | atic                                                                                                                                            | 2 Accident investigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | M 1 ☐ Yes 2 ☐ No                                                               |                                       |                            |                                                     |  |
| 2        | r Atterde                                                                                                                                                                                                                                                                                                                          | Certification:                                                                                                                                  | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, s building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | treet, factory, office                                                         | 28f. Location (Stree<br>City or Town, | eet and Number (<br>State) | or Rural Route Number,                              |  |
| ב        | ital c                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                       |                            |                                                     |  |
|          | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | edical                                                                                                                                          | 29a. Certifier  (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only ( |                                                                                |                                       |                            |                                                     |  |
|          | thin 2 the                                                                                                                                                                                                                                                                                                                         | Med                                                                                                                                             | one) and manner stated.  29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 29c. License number                                                            | 29                                    | d. Date signed //          | Month, Day, Year)                                   |  |
|          | 5 1 k 1                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | CLII                                                                           | 7                                     | 9                          | ) 4/ nf                                             |  |
|          | 141                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                 | 20. Name and widoos of pages who completed a vive of death (Nam 200) The                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Print)                                                                         | 1                                     | 0 12                       | 1108-                                               |  |
| 1        | 47.                                                                                                                                                                                                                                                                                                                                | 30. Name and offices of person who completed cause of death (Item 23a) (Type, Print)  NASREEN KANGO MD - 7610 CARROLL AVE: TAKOMA PARK MD 20912 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                       |                            |                                                     |  |
| Ü        | Sta                                                                                                                                                                                                                                                                                                                                | te                                                                                                                                              | 31. Date filed (Month, Day, Year)  32 Registrar's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                       |                            |                                                     |  |
|          | Registr                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                 | FFR 2 9 2008 Para 16 do                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | acts 1                                                                         |                                       |                            |                                                     |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Edward 'Bud' Franklin Waugh 2038 /Medical 4a. Facility Name (If not institution, give street and 4c. County of Death Examiner Baltimore City If Under Date of Birth (Month, Day, Year) 9. Birthplace Country) Security Numbe **Funeral** Months Days Min. Hours 1 □ M 2 □ F December 10 1936 Baltimore, Maryland Director 213 34 7504 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County death with the Marylan or items 23a or 28a-f show at 1 ☐ Yes 2 ☑ No Examiner must be notified Lutherville Director Baltimore Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21093 1604 Greenspring Drive USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2☐No Yes, Give 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 ☐ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NAAssociation of Maryland Pilots Dispatcher permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If Item 27 Is marked other any injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn Dorothy Ittner Arthur Savage Waugh ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 412 Lees Mill Road Hampstead, Maryland 21074 Cheryl L Dively (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ty Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley mem. Gdns. February 28 2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy 1 Live birth 2 Fetal death Month Year Day 4□Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No ed by the a detached t 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 □ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performe death? certificate l 2□ No 25 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3□ DOA 1 🗌 Yes 1 □ patient 2 ER/Outpatient P this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After Hospital or Attending 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:03 A<sup>M</sup> FEBRUARY 24, 2008 Oliver Walton (nmn) /Medical. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Apt. C Harford 596 Riley Court Joppatowne 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** MM 2 F Yrs. Director 257-60-0394 1939 Georgia 68 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or iteme 23e or 28e-f ehow troumstic event, the Madical Examinar must be notified at 1 ☐ Yes 2X No Maryland Harford <u>Joppatowne</u> Direct 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number with 596 Riley Court 21085 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1√Yes 2 No 1 → Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. filed within College (1-4or 5+) Elementary/Secondary (0-12) Soldier U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental h Pages 1 and 2 should be Annie E. Warren Willard (nmn) Walton Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is eny injury or other tree once. Teri Cook-Brown / Daughter 823 North Gap Loop, Montgomery, AL 36110 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) 3 - 1 - 08Richland, Georgia Bryant Cemetery 21. Signatu Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complication—that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Due to (or as a consequent of): 10 ma /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 V No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Disbetes meilitus type 2 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed peen 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cete hes t page 2 s certificate 1 Yes 2 No director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 A Residence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3□ DOA this. After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 Tes 2 No investigation Director: 2 Accident within 24 hours after de To the Funerel Directo completely filled in by th 3 ☐ Suicide 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

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Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 2121

State Registrar

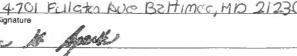
29b. Signature and title of certifier

Vilber

ROCSC MO 32. Registrar's Signature 31. Date filed (Month, Day, Year)

R

Mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

00045

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav 11:49 PM ANNA MAY WHITE 27,2008 FEBRUARY 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 M 2 X 218-10-4484 88 Aug. 11, 1919 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 →No Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 1008 James Street 21014 USA 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances E. Wilson John Raymond Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph E. White / Son 1006 James Street, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Removal from State tval 2 □ cremation Darlington Cemetery 4 Donation 5 Dother (Specify) 3-3-08 Darlington, Maryland 21. Signal re of Fun rivice License 22. Name and Address of Fecility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Palt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hdult DISTRESS SAN drome Due to (or as a consequence of): 14/trsystem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) uptured Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Lany Fof Death 1 / tural 2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work?

that the death certificate be executed the attending physician Physician/Medical þ Completed certificate has Be Medical Certification: To

**Physician** /Medical **Examiner** 

Physician

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 Yes 2 No

5 Pending investigation

6 ☐ Could not be

28b. Time of Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 Suicide

4 ☐ Homicide

31. Date filed (Month, Day,

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number

Rebinary 28, 2008

29d. Date signed (Month, Day, Year)

30. Name and address of per completed cause of death (Item 23a) (Type, Print) amora

7a, 500 Upper Chesafeeke Drive

State Registrar



Hospital or To the Hospital within 24 hours a To the Funeral C

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Decedent's Name (First, Middle, Last) [                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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Time of Death                                                                                                                                                                                                                                                                |  |
|                       | Physici<br>/Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                            | ALICIA W. 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| Maryland 21215-0036   | should be filed within 72 hours after death with the Maryland rund Mental Hygiene. In Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Completed by                                               | 3√7Widowed 4 □ Divorced Year or Dates:  15. 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Box 6   | The law requires that the death certific the has been signed by the attending page 2 should be detached for use as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Certification: To Be Completed by Physician/Medical        | IF FEMALE:   23b. 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Box 6 | The law requires that the death certific the has been signed by the attending page 2 should be detached for use as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | edical Certification: To Be Completed by Physician/Medical | IF FEMALE:   23c. If yes, outcome pf pregrant in the past 12 months?   1 Live birth 2 Fe   Fending investigation   25. Was case referred to medical examiner?   1 Live birth 2 Fe   Fending investigation   26. Date of injury (Month, Day Year)   27. Manner of Death   1 Live birth 2 Fe   Fending investigation   28a. Date of injury (Month, Day Year)   29a. Certifier (Check only one)   29a. Certifier (Check only one)   25. Medical Examiner: On the basis of examinary and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | pancy tal death 3 [ death 5 [ sulting in the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of the unit of t | 26. 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State) cause(s) and modate and place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | onth Day Year  Intribute to the cause of death?  3 Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Ther (Specify)  Inter or Rural Route Number,  Inter as stated.  In and due to the cause(s)                           |  |

Certification: To

Medical

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes

25. Was case referred to medical 1 Yes 2 No 27. Mann of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28b. Time of Injury 1 ☐ Yes 2 ☐ No

2 ER/Outpatient 3 DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 🗓 🖙 fifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEIDE JOH~

FRO ERICK, MD-20678

26. Place of Death (Check only one)

Registrar

After this

To the Hospital within 24 hours at To the Funeral Completely filled in

31. Date filed (Month, Day, Year)

32. Registrant Signature

Hospital: 1 | Inpatient

2008 **FEB 13** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06323 State of Maryland / Department of Health and Mental Hygiene [ amend #10e Per FH G877 3/36 of The of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Baize Day Prear 2008 e Muary 23 **Physician** Dollie 2-50 Am /Medical County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore If Under 1 Year | If Und Good Samaritan Nursing Center
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**/2** F Months Director 226-32-8982 85 October 17, 1922 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23s or 28e-f ehow the Medical Examinar must be notified at 1 XYes 2 ☐ No Director Baltimore Maryland the 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Belyedere 21239 U.S.A. 1601 East Belevedre Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Own Home 12 Homemaker 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be and Mental Charlie Redd Annie Moyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health tem 27 322 Hubbard Street, St. Reidsville, North Carolina Larry Baize 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 2-27-08 7 1 □ Removal from State
4 □ Donation 5 □ Other (Specify) permit. Page Department of Important; if any injury or once. = 5 BlueStoneChurchCemetery Pelham, North Carolina 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee michael 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 20 Physician /Medical Due to (or as a consequence of): Examiner Myra 291 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit Hospital or Attending Physician: The jaw requires that the death certificate be executed Due to (or / a consequence of): Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐ Pregnant at time of death 5 Other (specify) P.O. ed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ g a 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to comptetion of cause of death? 24a. Was an certificate hes t irector, page 2 si 1 Yes 2 X No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA his funeral 27. Martner of De th 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending efter death. I Director: Af d in by the fur 1 Tyes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours eft re Funeral Di letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely f (Check only one) ۽ 29c. License number 6 6 29b. Signature and title of certified 30. Name and address of person who completed cause death (Item, 23a), (Type, Print) Ballinge, Kd 5001

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

**ORIGINAL** 

GER OF L

32. Registrár's Signature

part gran

2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9,2008 **Physician** Feb. 10:05 p M Bischoff Elizabeth /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Regency Park Assisted Living Gambrills Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 18, 1927 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🛱 F 80 131-18-4035 Brooklyn NY Director Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits MD Anne Arundel 1 ☐ Yes AND No Director Severn 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r items 23a c USA 1580 Provincial Lane 21144 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify. þ Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Education 7 is marked other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Farrar Rose McMahon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Rosemary B. Hammond Daughter 1580 Provincial Lane Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. Burial 2 Cremation 3 Removal from State Lakeview Memorial Park 2/14/2008 | Cinnaminson, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) by Physician/Medical Completed Be ဥ

Examiner To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed attending physician and for use as the bunal-tra Division or Vital Records, P.O. Box 68760, To the Funeral Director: completely filled in by the within 24

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown        |                                                                              | 23d. Date of delivery<br>Month Day Year                          |  |  |
|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------|--|--|
| Part II. Other significant conditions o                                                 | ontributing to death but not resulting in the underlying cause given in                                                                                     | Part I. 23e. Did tobacc 1 ☐ Yes  24a. Was an                                 | 2 Due 3 Probably 4 Unknow                                        |  |  |
|                                                                                         |                                                                                                                                                             | autopsy performed 1  Yes 2 ₽                                                 | ? prior to completion of cause of death?                         |  |  |
| 25. Was case referred to medical examiner?                                              |                                                                                                                                                             | Place of Death (Check only one)                                              |                                                                  |  |  |
| 1 Yes                                                                                   | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:                                                                                                    | I ☐ Nursing Home 5 ☐ Residence                                               | 6 Definer (Specify)                                              |  |  |
| 27. Man of Death 1 Latural 5 Pending 2 Accident investigation                           | 28a. Date of Injury (Month, Day Year)  28b. Time of Survey of Survey at Work?  M 1 ☐ Yes                                                                    | 28d. Describe how in 2 □ No                                                  | njury occurred                                                   |  |  |
| 3 ☐ Suicide 6 ☐ Could not be determined                                                 | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                                                      | 28f. Location (Street<br>City or Town, St                                    | treet and Number or Rural Route Number,<br>n, State)             |  |  |
| 29a. Certifier (Check only one)                                                         | ysician: To the best of my knowledge, death occurred at the time, tiner: On the basis of examination and/or investigation, in my opinion and mainer stated. | late and place, and due to the cause<br>on, death occurred at the time, date | e(s) and manner as stated.<br>and place, and due to the cause(s) |  |  |
| 29b. Signature and the of certifier                                                     | Hours 29c. License num                                                                                                                                      | nber 29d.                                                                    | Date signed (Month, Day, Year)                                   |  |  |
| 30. Name and address of person who                                                      | completed cause of death (Item 23th) (Type, Prip)                                                                                                           | e, blen Bu                                                                   | hie, w1,2106                                                     |  |  |
| 31. Date filed (Month, Day, Year)                                                       | 32. Registrar's Signature                                                                                                                                   |                                                                              | /                                                                |  |  |
| FEB 12                                                                                  | 2008 More St. Sparke                                                                                                                                        |                                                                              |                                                                  |  |  |

Certification:

Medical

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 8:00 A<sub>M</sub> February 22, 2008 Helen Lorraine Broome /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 21690 Cryer Road Avenue St. Mary's 8. Date of Birth (Month, Day, Year)
July 2, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 🕅 F 76 Maryland Yrs. 1931 Director 217-24-4876 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 No St. Mary's Avenue Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or must be r 20609 21690 Cryer Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an "natural", or items Medical Examiner me 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White <u>ک</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Government Contractor 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) US Government the alth and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Whelimina Margaret Kramer 1 and 2 should b Health and Ment Louis Federline traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health 3 Important: If item 27 is any Injury or other tra Constance Crawford / Daughter 15491 Turnberry Drive Haymarket, VA 20169 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State February 25, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 20 Michael Leonardtown, MD 20650 tardener Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. 23a. Part1 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of law requires that the death certificate be executed burial-tra Due to (or as a consequence of) or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Month Vear 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🔲 Yes No 3 Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed?

1 Yes 2 No Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3□ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Injury 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after dear To the Funeral Director completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 🕦 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature a 29d. Date signed (Month, Day, 0 00022/02 30. Name and addrest of person who completed cause of death (Item 23a) (Type, Print) MARKET DRIVE, Charlote All, MD 2062 Z State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:00 PM Joseph Cover February 10, 2008 Deaver /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's 16701 Dorchester Place Upper Marlboro 8. Date of Birth Month, Day, Year) Apr 18, 1946 if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7 Age (In vrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days Maryland 1 X M 2 □ F 61 219-46-9620 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a, State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 X No Upper Marlboro Funeral Director Prince George's 10g. Citizen of What Country? 10e. Street and Number 20772 IISA 16701 Dorchester Place 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Self Employed Master Plasterer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental Fe11 Richard Victor Cover Evarilla P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1452 Middletown Road Annapolis, MD Amanda Foran (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Feb 15 Department of himportant: If ite any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. View Cemetery 2008 Marriottsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of yneral Service Licensee Lee Funeral Home Calvert, PA Gary J. Goff Owings. MD 20736 8125 Southern Maryland Blvd. 23a. Part. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to ( as a consequence of): disease or condition resulting in death) /Medical **Examiner** Due to lows consequence of): Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy atten for u Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an 1☐ Yes 2 No 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide determined within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 133069 February 11, 2008 Eric Berstein, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Detense Hunayolus 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB28

2008

32. Registrar's Signature

Registrar

31. Date filed (Month, Day,

FEB 1 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend PI line a-b, PII, 25, perME, g877 Weath of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Ам 9:40 February 19, 2008 William Carson Campbell /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Lusby 326 Johnson Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6 Sex **Funeral** Days Months Hours 1 X M 2 7 F 241-16-4959 September 15,1923 North Carolina 84 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 28a-f show 1 ☐ Yes 2 ☑ No notified Director Lusby Calvert Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Pe P USA 20657 or items 23a 326 Johnson Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Community Resources County Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Eve Harrelson Malcom Arthur Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lusby, MD 20657 Cheryl Wiggin Campbell / Wife 326 Johnson Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State February 21 Middleham/St.Peter's Lusby, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown. MD 20650 Jardener 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DISSEMINATED INTRAVASCULAR COAGULATION [DIC] disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** NEUMONIA Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examine s been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown HITM HYPOXIC ENCEPHALOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Paraplegia due to transverse myelitis; hypertension cate has page 2 s performed 2 No 1 TYes 1 Yes 2 HNo certificate or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death Check onl one Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760 Division or Vital Records,

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu filled in by Hospital the

State

29a. Certifier (Check only 29b. Signature and title of certifier

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 736969

LUSBY

29d. Date signed (Month, Day, Year) 2 20 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATHEW MD PO BOX 1789

31. Date filed (Month, Day, Year) 20



Registrar

Mark Courtney
08-01337
UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| IK UNK                                                                                                                                                                                                                                                                                                                                                | 1-             | State of Maryland / Department of Health and Wertai Fly For State Certificate of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | /glene<br>Reg.          | No. 20                            | 08 0633                                       |
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| Dhysisis                                                                                                                                                                                                                                                                                                                                              | R              | edistrar<br>. Decedent's Name (First, Middle,Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2 Date of Death         |                                   | 3. Time of Death                              |
| Physicia<br>edical Examir                                                                                                                                                                                                                                                                                                                             |                | Mark Darnell Courtney                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Month E<br>February 16  | , 2008                            | 0303 hrs                                      |
|                                                                                                                                                                                                                                                                                                                                                       | 4              | a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 4c. County of Dea<br>Prince Georg |                                               |
|                                                                                                                                                                                                                                                                                                                                                       |                | Rt. 210 N/B @ Pine Drive Accokeek                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | In Date of Birth        | (MM/DD/YYYY) 9. E                 |                                               |
| Funeral                                                                                                                                                                                                                                                                                                                                               | 5              | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | Fore                              | eian                                          |
| Director                                                                                                                                                                                                                                                                                                                                              |                | 220-78-0777 1XM 2F 34 Yrs Yrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 03/09/1                 | 973                               | Maryland Maryland                             |
| y.                                                                                                                                                                                                                                                                                                                                                    | _              | Jsual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                   | 10d. Inside City Limits                       |
| ow any                                                                                                                                                                                                                                                                                                                                                |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                   | 1 Yes 2 X No                                  |
| Maryland<br>28a-f show<br>datonce.                                                                                                                                                                                                                                                                                                                    | je P           | Maryland St. Mary's   Charlotte Hall                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 100                     | . Citizen of What Co              | ountry?                                       |
| th the Maryland<br>23a or 28a-f sho<br>notified at once.                                                                                                                                                                                                                                                                                              | Director       | 30390 White Drive 20622                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 13                      | nited Sta                         | tes                                           |
| MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matte event, the Medical Examiner must be notified at once                                                                                                                           |                | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | pecify Yes or No-       | 14. Race - Am<br>White, etc       | erican Indian, Black,                         |
| eath v                                                                                                                                                                                                                                                                                                                                                | Funeral        | 1 X Never Married 2 Married 2 X No If Yes, specify Cuban, Mexican, Puerto                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | rican, etc.)            |                                   |                                               |
| after d                                                                                                                                                                                                                                                                                                                                               | by F           | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | Specify:<br>16b. Kind of Busines  | Black                                         |
| natur                                                                                                                                                                                                                                                                                                                                                 | eted t         | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | TOD. KING OF BUSINES              | )                                             |
| 36<br>n 72 h<br>nan ",<br>lical E                                                                                                                                                                                                                                                                                                                     | plet           | Elementary/Secondary (0-12) College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | Landscap                          | ing                                           |
| 5-0036<br>iled within 7<br>Hygiene.<br>I other than<br>the Medica                                                                                                                                                                                                                                                                                     | omp            | 9 Landscaper 17. Father's Name (First, Middle, Last) 18. Mother's Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | e (First, Middle, M     | aiden Surname)                    |                                               |
| 1215-0036<br>d be filed within 72<br>fental Hygiene.<br>narked other than '                                                                                                                                                                                                                                                                           | 91             | Agnes C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | . Holt                  | 10-10-0-1-1                       |                                               |
| 212<br>ould b<br>Ment<br>mark                                                                                                                                                                                                                                                                                                                         | 2              | 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                   | 1                                             |
| MD<br>d 2 sho<br>Ith and<br>n 27 is<br>aumat                                                                                                                                                                                                                                                                                                          |                | Agnes C. Courtney/Mother 41900 Stephen Young                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Court, L                | eonardtow<br>20c. Location - City | m MD 20650                                    |
| re, l<br>1 and<br>1 Heal<br>f item<br>er tra                                                                                                                                                                                                                                                                                                          |                | 20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                   |                                               |
| Pages<br>sent of<br>ant: 1                                                                                                                                                                                                                                                                                                                            | - 1            | Charles Memorial Cem   02/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | Leonardt                          |                                               |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical                                                                                                                                             |                | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Br                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                   |                                               |
|                                                                                                                                                                                                                                                                                                                                                       |                | Shawn Aylsworth Mossian 22955 Hollywood R 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | or respiratory arre     | nardtown,<br>est, shock, or heart | Approximate interval                          |
| Physician<br>/Madical                                                                                                                                                                                                                                                                                                                                 |                | failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                   | Between Onset and<br>Death                    |
| aminer                                                                                                                                                                                                                                                                                                                                                | - 1            | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                   |                                               |
| `                                                                                                                                                                                                                                                                                                                                                     |                | Sequentially list conditions, b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                   |                                               |
|                                                                                                                                                                                                                                                                                                                                                       | je l           | if any, leading to immediate cause. Enter Underlying Cause                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                   |                                               |
|                                                                                                                                                                                                                                                                                                                                                       | Examiner       | (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                   |                                               |
| executed<br>an and<br>al - transit                                                                                                                                                                                                                                                                                                                    | ũ              | d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                   |                                               |
| 50,<br>te be executed<br>ysician and<br>burial - transit                                                                                                                                                                                                                                                                                              | ledical        | UNPENDED AMENDED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                   |                                               |
| Box 68760, eath certificate be the attending physic ed for use as the bur                                                                                                                                                                                                                                                                             |                | IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | nancy                   | 23d. Date of de<br>Month          | livery<br>Day Year                            |
| Sox 6876<br>death certificate<br>e attending phy<br>for use as the                                                                                                                                                                                                                                                                                    | gal            | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic preg                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                   |                                               |
| BOX<br>death<br>ne atte<br>d for u                                                                                                                                                                                                                                                                                                                    | Physician/N    | 1 Yes 2 No 9 Unknown g Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                   | to the agues of death?                        |
| that the d                                                                                                                                                                                                                                                                                                                                            |                | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                   | te to the cause of death?  Probably 4 Unknown |
| , P.O<br>ires that t<br>signed by                                                                                                                                                                                                                                                                                                                     | d by           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 24a. Was                |                                   | re autopsy findings available                 |
| ords, w requir                                                                                                                                                                                                                                                                                                                                        | Completed      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | auto                    | osy prio                          | or to completion of cause of ath?             |
| eco<br>he fav<br>ate has                                                                                                                                                                                                                                                                                                                              | l ii           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                   | Yes 2 No                                      |
| tal Recian: The certificate ector, page                                                                                                                                                                                                                                                                                                               | Be C           | 25. Was case referred to medical 26.Place of Death (Chec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                   |                                               |
| Vita                                                                                                                                                                                                                                                                                                                                                  | ۱ ٥            | 1 V Yes 2 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | sing Home 5             | Residence 6                       |                                               |
| Division of Vital Records, pital or Attending Physician: The law requinours after death.  retal Director: After this certificate has been sifiled in by the funeral director, page 2 should t                                                                                                                                                         | Ë              | 27. Manner of Death  1 Natural 5 Pending   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   28b. Time of Injury   28c. Injury at Work?   28c. |                         | struck by vehic                   |                                               |
| sion<br>ttend<br>death<br>ctor:                                                                                                                                                                                                                                                                                                                       | jä;            | 2 Accident Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 28f. Location           | Street and Number                 | or Rural Route Number, City                   |
| lor A<br>after<br>Dire                                                                                                                                                                                                                                                                                                                                | Certification: | Suicide Could not be determined (Specify) Major Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | or Town,<br>Rt. 210 N/B | State)<br>Pine Drive, Acc         | cokeek, MD                                    |
| ospita<br>hours<br>unera                                                                                                                                                                                                                                                                                                                              |                | 4 Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | and due to the cal      | se(s) and manner a                | s stated.                                     |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funcata Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit | lica           | one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ed at the time, date    | and place, and due                | e to the cause(s)                             |
| To To                                                                                                                                                                                                                                                                                                                                                 | Medical        | and manner stated.  29b. Signature and title of certifier  29c. License number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 29d. Date signed                  | (Month, Day, Year)                            |
|                                                                                                                                                                                                                                                                                                                                                       |                | O.C.M.E.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | February 17                       | , 2008                                        |
|                                                                                                                                                                                                                                                                                                                                                       |                | 30. Name and address of person who completed cause of death (Item 23a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 24                                |                                               |
| all                                                                                                                                                                                                                                                                                                                                                   |                | Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltim                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | nore, MD 212            | JT                                |                                               |
|                                                                                                                                                                                                                                                                                                                                                       | state          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                   |                                               |
| Regi                                                                                                                                                                                                                                                                                                                                                  | strai          | FFB 2 0 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                   |                                               |

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State of Maryland / Department of Health and Mental Hygiene

| emon Davis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1                            | For State Of Maryland / Department of Health and Mentain in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | -                                 | 200                             | 18 0633                                          |
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| Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                              | Registrar  1. Decedent's Name (First, Middle,Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Reg. I<br>2. Date of Death        |                                 | 3. Time of Death                                 |
| ledical Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | -                            | Vernon Davis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Month Da<br>February 17,          | 2008 Year                       | 1100 hrs                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4                            | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | h                                 | 4c. County of Death             |                                                  |
| , ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                              | 3000 Bright Seat Road G3 Lanham                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                   | Prince George                   |                                                  |
| Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                              | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                   | MM/DD/YYYY) 9. Birt<br>Foreig   | n                                                |
| Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | L                            | 215-64-6289 1x M 2 F 54 Yrs. 54 Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Feb.27                            | ,1953 <sup>c</sup> <sub>N</sub> | intry)                                           |
| ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | - 1-                         | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                   |                                 | 10d. Inside City Limits                          |
| ow any                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                   |                                 | 1 XYes 2 No                                      |
| le (LO)  or 28a-f show fied at once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | į.                           | Md. PG Lanham  10e. Street and Number 10f. Zip Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10g.                              | Citizen of What Cour            | ntry?                                            |
| th the Maryland 23a or 28a-f sho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Director                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                   | United S                        | tatos                                            |
| vith th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                              | 3000 Brightseat Road #G2 20706  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Specify Yes or No-                | 14. Race - Ameri                | can Indian, Black,                               |
| eath v                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Funeral                      | 1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | o Rican, etc.)                    | White, etc.                     |                                                  |
| iffer d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ğ<br>L                       | 3 Widowed 4 Divorced If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                   | Specify: Bla                    |                                                  |
| lours a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ֓֞֝֞֞֜֓֓֓֓֓֩֟֓֓֓֩֩֓֓֓֓֓֓֓֓֓֡ | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                   | 6b. Kind of Business/           | Industry                                         |
| 136<br>hin 72 h<br>e.<br>than "r                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ompleted                     | Elementary/Secondary (0-12) College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                   | Desiroto                        |                                                  |
| withi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 탉                            | 7 Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ne (First, Middle, Mai            | Private                         |                                                  |
| 21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "nature event, the Medical Exa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Be C                         | 17.1 dates o Harrie (1 live; middle) Eddy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | L. Davi                           |                                 |                                                  |
| y, MD 21215-0036<br>and 2 should be filed within 72 hours after death with the Maryland<br>fealth and Mental Hygiene.<br>tem 27 is marked other than "natural", or items 23a or 28a-f she<br>traumatic event, the Medical Examiner must be notified at once                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ᆰ                            | 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Rural Route Number                | er, City or Town, State         | e, Zip Code)                                     |
| MD<br>id 2 sho<br>alth and<br>m 27 is<br>aumati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              | Geneviene Davis/wife 3000 Brightseat Lanham Md 2070                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | h                                 |                                 |                                                  |
| Te, land land Healing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ШĪ                           | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Date 2                            | 20c. Location - City or         | Town, State                                      |
| MOI<br>Pages<br>ent of<br>int: T                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | П                            | 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other Specify:  Riverdale Park Crem.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 2/28/08                           | Riverd                          | lale, Md.                                        |
| Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Median injury or other traumatic event, the Median injury or other traumatic event, the Median injury or other traumatic event, the Median injury or other traumatic event, the Median injury or other traumatic event, the Median injury or other traumatic event, the Median injury or other traumatic event, the Median injury or other traumatic event, the Median injury or other traumatic event, the Median injury or other traumatic event, the Median injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event inju | ı                            | 21 Si ature of Funeral Service Licensee 22. Name and Address of Facility                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | odges &                           | Edwards                         | F.H.                                             |
| <b>0</b> 89 2 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1                            | Danna Halfer 3910 Silver Hi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 11 Rd.,                           | Suitland                        | Approximate Interval                             |
| Physician<br>/Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                              | 23a. Frt I. Enter the disease, or commetations that caused the death. Do not enter the mode of dying, such as cardiac bilure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | or respiratory arrest             | , snock, or near                | Between Onset and Death                          |
| aminer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1                            | Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   |                                 | Dean                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              | h                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                   |                                 |                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | اةِ                          | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                   |                                 |                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Examiner                     | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <u>.</u>                          |                                 |                                                  |
| nted<br>d<br>ansit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                              | events resulting in death) Last  Due to (or as a consequence of):  d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                   |                                 |                                                  |
| , P.O. Box 68760, res that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Medical                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | -                                 | 4                               |                                                  |
| 60,<br>ate be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Med                          | IF FEMALE: 23c. If yes, outcome of pregnancy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                   | 23d. Date of delive             |                                                  |
| 687<br>ertific<br>ding p                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | jan/                         | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specific)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | nancy                             | Month                           | Day Year                                         |
| Box 687  death certificathe attending ped for use as the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Physician/I                  | 1 Yes 2 No 9 Unknown 9 Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | - Av                              |                                 |                                                  |
| D. B<br>trthe d<br>ached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 튑                            | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 23e. Did tob                      | acco use contribute to          | the cause of death?                              |
| P.O.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 힐                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1 Yes                             | 2 No 3 Pro                      | bably 4 Unknown                                  |
| ords, w requir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Completed by                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 24a. Was ar                       |                                 | utopsy findings available completion of cause of |
| e faw                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | m<br>d                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | perform                           | ned? death?                     | res 2 No                                         |
| al Re(ian: The certificate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              | 25. Was case referred to medical 26.Place of Death (Chec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                   |                                 |                                                  |
| Vital Rec<br>ysician: The<br>this certificate<br>director, page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | o Be                         | examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other Nurs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | sing Home 5 R                     | esidence 6 🗸 Oth                | er: Scene                                        |
| of<br>ing Ph<br>After t<br>uneral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b></b> }                    | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 28d. Describe ho                  | w injury occurred               |                                                  |
| ion<br>itendi<br>leath.<br>tor: ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | atio                         | 1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year) 1 Yes 2 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                   |                                 |                                                  |
| Division of Vital Records, tal or Attending Physician: The law requir rs after death.  Al Director: After this certificate has been seled in by the funeral director, page 2 should be a constitution of the funeral director.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Certification:               | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 28f. Location (St<br>or Town, Sta |                                 | Rural Route Number, City                         |
| Hospital<br>24 hours<br>Funeral<br>tely filled                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                              | 4 Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                   | (a) and manner so at            | atod                                             |
| Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Medical                      | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a (Check only one)  2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred to the control of the basis of examination and/or investigation, in my opinion, death occurred to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the | d at the time, date a             | nd place, and due to            | the cause(s)                                     |
| To the Vithin 2 To the Complet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Med                          | and manner stated.  29b. Signature and title of certifier  29c. License number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | 29d. Date signed (M             |                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 111                          | Marine Dre Shell O.C.M.E.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   | February 18, 20                 | 008                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              | 30. Name and address of person who completed cause of death (Item 23a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                   |                                 |                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              | Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | D 21201                           |                                 |                                                  |
| Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ate                          | 31. Date filed (Month, Day Year) 9 2008 32. Registrar's Signature,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                   |                                 |                                                  |
| Regist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | and                          | LD V & COOL TOWN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                   |                                 |                                                  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Irma Evelyn Decker 13, 2008 Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Solomons Nursing Center Solomons Calvert If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 1 F Director 401-62-4266
Usual Residence of Decedent 2/22/1911 NY 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show notified at 1X Yes 2 □ No Director MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a 706 Charlotte Court 20678 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n and Mental Hygiene. 4 Homemaker Own Home traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Wilson 2 Leslie Gregory 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other trau 2515 Potts Point Rd., Huntingtown, MD 20639 Janice Nimmer/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 💆 Removal from State 4 □ Donation 5 🖔 Other (Specify) entombed | Owensboro Gdns. 2/21/08 Owensboro, KY 21. Signature of Funeral Service Licensee/ 22. Name and Address of Facility Raymond-Wood F.H., P.A. V. Woor PO Box 430, Dunkirk, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CEREBRO VASCULAR ACCIDENT Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and-tranphysician ar s the burial-t Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Munner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 VI atural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident I Director; d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Artendin Physici-30. Name and address of person who completed cause of Aath (Item 23 (Type, Print)

chw 10

Anwar Munshi, M.D. 110 Hospital

110 Hospital Road #303 Prince Frederick, MD 20678

State Registrar 31. Date filed (Month, Day, Year) 32. Registra's Signature

FEB 1 5 2008

|                |                                                                                                                                                                                                                                                                    |                | For<br>State                                                                              |                                         | State of Ma                                                      | aryland /                     | -                      | artment of I<br><i>rtificate of</i>    | lealth and <b>l</b><br>Death               | Mental Hy                       | giene<br>Reg. No. | 2008                         | 06334                                              |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------------------------------------|-------------------------------|------------------------|----------------------------------------|--------------------------------------------|---------------------------------|-------------------|------------------------------|----------------------------------------------------|
| 6              |                                                                                                                                                                                                                                                                    |                | Registrar  1. Decedent's Name                                                             | e (First, Middle, La                    | ast)                                                             |                               |                        | timodito or                            | Boun                                       | 2. Date of De                   | eath              |                              | 3. Time of Death                                   |
|                | Physicia<br>/Medic                                                                                                                                                                                                                                                 | _              | Thomas                                                                                    | Francis                                 | Drury                                                            |                               |                        |                                        |                                            | Februa                          | ry 13             | , 2008                       | 1:30 PM                                            |
|                | Examin                                                                                                                                                                                                                                                             | _              |                                                                                           |                                         | ve street and number)                                            |                               |                        |                                        | or Location of Death                       | h                               |                   | County of Dea                |                                                    |
| 1              | B1                                                                                                                                                                                                                                                                 |                | 2509 Jeni<br>5. Social Security No                                                        |                                         |                                                                  | e (In yrs. last               | hirthday)              | Silver<br>If Under 1 Year              |                                            | 8. Date of Bi                   |                   | ntgome:                      | ry<br>thplace (State or Foreign                    |
| Ŀ              | Funeral<br>Director                                                                                                                                                                                                                                                |                | 076-34-54                                                                                 | 434                                     | 1 <b>X</b> M 2□F                                                 | 66                            | Yrs.                   | Months Days                            |                                            | Oct 31                          | ay, Year)         | Co                           | Vork                                               |
|                | land<br>ow<br>t                                                                                                                                                                                                                                                    |                | Usual Residence of<br>10a. State                                                          | 10b. County                             |                                                                  | 10c. City, T                  | own or Lo              | cation                                 |                                            |                                 |                   |                              | 10d. Inside City Limits                            |
|                | Mary<br>i-f sho<br>fied a                                                                                                                                                                                                                                          | tor            | MD                                                                                        | Montgome                                | erv                                                              | Silver                        | Spr                    | ing                                    |                                            |                                 |                   |                              | 1 □Yes 2 No                                        |
|                | th the                                                                                                                                                                                                                                                             | Director       | 10e. Street and Nun                                                                       |                                         |                                                                  |                               |                        | 10f. Zip Code                          |                                            |                                 | 10g. Citiz        | en of What Co                | ountry?                                            |
|                | 23a c                                                                                                                                                                                                                                                              | ral            | 2509 Jenr                                                                                 | nings Cou                               |                                                                  |                               |                        | 20902                                  |                                            |                                 | USA               |                              |                                                    |
| 0              | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. To its marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | Funeral        | <ul><li>11. Marital Status</li><li>1 ☐ Never Marri</li></ul>                              | ied 2X Married                          | 12. Was Decedent   Armed Forces?                                 | Ever in U.S.<br>No            |                        |                                        | Hispanic Origin? (S<br>pan, Mexican, Puert | pecify Yes or Note Rican, etc.) |                   | 4. Race - Ame<br>Black, Whit |                                                    |
| 5-0036         | ours a                                                                                                                                                                                                                                                             | d by           | 3 Widowed                                                                                 | 4 Divorced                              | If Yes, Give<br>Year or Dates:                                   |                               |                        | 1∐Yes 2 <b>X</b> INo                   |                                            |                                 |                   |                              | nite                                               |
| <u>2</u>       | "natu<br>"natu                                                                                                                                                                                                                                                     | Completed      | (Spec                                                                                     | 15. Decedent's E<br>ify only highest gr | ducation<br>rade completed)                                      | 1                             | 6a. Deced              | tent's Usual Occu<br>kind of work done | pation<br>during most of wor<br>ed)        | rking                           | 16b. Kin          | d of Business                | /Industry                                          |
| 2121           | withir<br>lene.<br>than<br>the Ma                                                                                                                                                                                                                                  | duic           | Elementary/Secon                                                                          | ndary (0-12)                            | College (1-4or 5                                                 |                               |                        | h Statis                               |                                            |                                 | Fede              | eral Go                      | vernment                                           |
| ק<br>ק         | e filed<br>Il Hyg<br>other                                                                                                                                                                                                                                         | Be C           | 17. Father's Name (                                                                       | (First, Middle, Las                     |                                                                  |                               |                        |                                        | 18. Mother's Nan                           | ne (First, Middle               | e, Maiden S       | Surname)                     |                                                    |
| Maryland       | uld be<br>Menta<br>Menta<br>arked<br>arked                                                                                                                                                                                                                         | To B           | Patrick I                                                                                 | rury                                    |                                                                  |                               | _                      |                                        | Mary McF                                   | Kinney                          |                   |                              |                                                    |
| lar)           | 2 sho<br>and is ma<br>is ma                                                                                                                                                                                                                                        | 1              | 19a. Informant's Na                                                                       | ame/Relationship                        | (Type. Print)                                                    | 1                             |                        |                                        | t and Number or Ru                         |                                 |                   |                              |                                                    |
| e)<br>O        | 1 and<br>Health<br>Sm 27<br>ther to                                                                                                                                                                                                                                |                | Margaret<br>20a. Method of Disp                                                           |                                         | ife                                                              |                               |                        | Jennings                               | Court Si                                   | <u>ilver Sp</u>                 |                   | MD 20<br>cation - City or    |                                                    |
| nor            | Pages<br>nent of I<br>int: If ite                                                                                                                                                                                                                                  | ĺ              | 1 ☐ Burial 2                                                                              |                                         | Removal from State                                               | cem                           | etery, crer            | matory or other pla                    | ory 02/                                    |                                 |                   | sville,                      |                                                    |
| Baltimore,     | permit. Pages Department of I Important: If ite any injury or of                                                                                                                                                                                                   |                | 21. Signature of Fu                                                                       |                                         |                                                                  | Onese                         | -                      |                                        | ess of Facility<br>Cremation               |                                 |                   |                              |                                                    |
| m<br>—         | a in See                                                                                                                                                                                                                                                           |                | 1.630                                                                                     | verly L                                 | Heilto                                                           | MO1251                        | l Be                   | verly L.                               | Heckrott                                   | te. P.A.                        | Cla               |                              | Le. MD 21029                                       |
|                |                                                                                                                                                                                                                                                                    |                | shock, or hea                                                                             | rt failure. List onl                    | nplications that caused<br>y one cause on each li                | the death. I                  | Do not ent             | er the mode of dy                      | ing, such as cardia                        | c or respiratory                | arrest,           |                              | Approximate<br>Interval Between<br>Onset and Death |
|                | Physician                                                                                                                                                                                                                                                          |                | Immediate Cause (<br>disease or condition<br>resulting in death)                          | Final<br>n                              | a. Cerebral                                                      |                               |                        | Accident                               |                                            |                                 |                   |                              | 6 years                                            |
|                | /Medical<br>Examiner                                                                                                                                                                                                                                               |                | recurring in ecourity                                                                     |                                         | Due to (or as                                                    | a consequen                   | ice of):               |                                        |                                            |                                 |                   |                              |                                                    |
| ì,             | Tree St                                                                                                                                                                                                                                                            | Jer            | Sequentially list cor<br>if any, leading to im<br>cause. Enter Under<br>Cause (Disease or | nditions,<br>nmediate                   | b Due to (or as                                                  | a consequen                   | ice of):               |                                        |                                            |                                 |                   |                              |                                                    |
|                | cuted<br>nd<br>ransit                                                                                                                                                                                                                                              | Examiner       | Cause (Disease or that initiated events resulting in death) L                             | injury                                  | C                                                                |                               |                        |                                        |                                            |                                 |                   |                              |                                                    |
| 60,            | ficate be executed<br>physician and<br>s the burial-transit                                                                                                                                                                                                        |                | resulting in death) L                                                                     | _ast                                    | Due to (or as                                                    | a consequen                   | ice of):               |                                        |                                            |                                 |                   |                              |                                                    |
| 58760,         | physic<br>physic<br>the b                                                                                                                                                                                                                                          | edical         |                                                                                           |                                         | d                                                                |                               |                        |                                        |                                            |                                 |                   |                              |                                                    |
| ×              | certi<br>ding<br>se a                                                                                                                                                                                                                                              |                | IF FEMALE:<br>23b. Was decedent                                                           | t pregnant                              | 23c. If yes, outcome                                             |                               |                        |                                        |                                            |                                 | 2                 | 3d. Date of de               | elivery                                            |
|                | 0 0                                                                                                                                                                                                                                                                | Physician/M    | in the past 12<br>1 ☐ Yes 2 ☐                                                             | months?                                 | 1 ☐ Live birth 4 ☐ Pregnant at                                   |                               |                        | Ectopic pregnand<br>Other (specify)    | су                                         |                                 |                   | Month                        | Day Year                                           |
| о.<br>О        | at the de<br>I by the stached                                                                                                                                                                                                                                      | hys            | 9 🗆 Unknown                                                                               |                                         | 9∐Unknown                                                        |                               |                        |                                        |                                            | 00- P/4                         |                   |                              | to the cause of death?                             |
|                | The law requires that the tee has been signed by the sage 2 should be detache                                                                                                                                                                                      | by             | Diabetes                                                                                  |                                         | contributing to death b                                          | ut not resultin               | ig in the ui           | nderlying cause g                      | ven in Part I.                             |                                 |                   |                              | Probably 4XIUnknown                                |
| Vital Records, | law require<br>as been sig<br>2 should b                                                                                                                                                                                                                           | Completed      | Hypertens                                                                                 | sion                                    |                                                                  |                               |                        |                                        |                                            | 24a. Wa                         | s an<br>opsy      | 24b. Were a                  | utopsy findings available completion of cause of   |
|                |                                                                                                                                                                                                                                                                    | Com            | Gastric I                                                                                 | Feeding '                               | Гubе                                                             |                               |                        |                                        |                                            | per<br>1□ Yes                   | formed?           | death?<br>1 ☐ Ye             |                                                    |
| VII<br>K       | ilcian: Tr<br>certificate<br>ector, pag                                                                                                                                                                                                                            | Be             | 25. Was case reference examiner?                                                          |                                         | Hospital:                                                        |                               |                        | _ lo                                   | 26. Place of Dea                           |                                 |                   |                              |                                                    |
| ō              | Phys<br>r this<br>ral dir                                                                                                                                                                                                                                          | . To           | 1 ☐ Yes 2 ☐X                                                                              |                                         | 1 ☐ Inpatie                                                      | ent 2 ER                      | Outpatier  Bb. Time of |                                        | her: 4 Nursing F                           | Home 5 Res                      |                   |                              | ecify)                                             |
| on             | nding Fith.<br>:: After<br>: funera                                                                                                                                                                                                                                | tion           | 1 XNatural<br>2  Accident                                                                 | 5 ☐ Pending investigation               | (Month, Da                                                       |                               | Injury                 |                                        | ork?<br>⊒Yes 2 □ No                        |                                 |                   |                              |                                                    |
| Division or    | if or Attend<br>after death<br>  Director: ,<br>  d in by the f                                                                                                                                                                                                    | Certification: | 3 ☐ Suicide<br>4 ☐ Homicide                                                               | 6 Could not determined                  | 20e. Flace of III)                                               | ury - At home<br>c. (Specify) | e, farm, str           | reet, factory, office                  |                                            | 28f. Location<br>Cify or To     | (Street and       | d Number or F                | Rural Route Number,                                |
| ō              | ital or<br>irs afte<br>ral Di                                                                                                                                                                                                                                      | Cert           |                                                                                           | v. v. v                                 | TI TI                                                            |                               |                        |                                        |                                            |                                 |                   |                              |                                                    |
|                | To the Hospital or Attending Physician: within 24 hours after death:  To the Funeral Director: After this certifical completely filled in by the funeral director,                                                                                                 | Medical        | 29a. Certifier<br>(Check only<br>one)                                                     |                                         | hysician: To the best<br>aminer: On the basis o<br>and manner st | of examination                |                        |                                        |                                            |                                 |                   |                              |                                                    |
|                | Vithin<br>To th<br>comp                                                                                                                                                                                                                                            | Me             | 29b. Signature and                                                                        |                                         |                                                                  |                               |                        | 29c. Licer                             | ise number                                 |                                 | 29d. Date         | e signed (Mor                | nth, Day, Year)                                    |
|                |                                                                                                                                                                                                                                                                    |                | Nou                                                                                       | eit Her                                 | and MD                                                           |                               |                        | D5552                                  | 22                                         |                                 | Febru             | ary 14                       | , 2008                                             |
| (5             | )00                                                                                                                                                                                                                                                                |                |                                                                                           |                                         | completed cause of d                                             |                               |                        |                                        | TON Comi                                   | no MD                           | 20010             |                              |                                                    |
| 4              | % Sta                                                                                                                                                                                                                                                              | te             | Robert Ge                                                                                 | th, Day, Year)                          | .D. 1500 Fo                                                      | ar's Signature                | e                      |                                        | rver shtm                                  | ng, rm .                        | 70310             |                              |                                                    |
|                | Registi                                                                                                                                                                                                                                                            |                |                                                                                           | FEB 15                                  | 2008                                                             | CARLO A                       | H. A                   | perte                                  |                                            |                                 |                   |                              |                                                    |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | For<br>State<br>Registrar                                                                                   | State of Ma                                                      | iryiano / i            | Certificate of                                                                  |                                           |                                         |                                    | 08                            | 06335                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------|---------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------|------------------------------------|-------------------------------|----------------------------------------------|
| Physici                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | an             | 1. Decedent's Name (First, Middle, Las                                                                      | st)                                                              |                        |                                                                                 |                                           | Date of Dea     Month                   | Day                                | Year                          | 3. Time of Death                             |
| /Media                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | al             | Inge Deacon  4a. Facility Name (If not institution, give                                                    | ctroot and number                                                |                        | 4h City Town o                                                                  | r Location of Death                       |                                         | ry 9, 20                           |                               | 8:08 A M                                     |
| Examir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | er             |                                                                                                             |                                                                  |                        |                                                                                 |                                           | 1                                       |                                    | Arun                          | do1                                          |
| Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | Anne Arundel Medi 5. Social Security Number 6. S                                                            | ex 7. Age                                                        | e (In yrs. last bii    | rthday) If Under 1 Year                                                         |                                           | 8. Date of Birt<br>(Month, Da           | th I                               |                               | ce (State or Foreign<br>y)                   |
| Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | 218-74-6616                                                                                                 | □M 2ÅF 7                                                         | 2                      | Yrs. Months Days                                                                | Hours Min.                                | 6/5/19                                  | 935 _                              | Germa                         |                                              |
| and w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | Usual Residence of Decedent  10a. State 10b. County                                                         |                                                                  | 10c. City, Tow         | n or Location                                                                   |                                           |                                         |                                    | 100                           | d. Inside City Limits                        |
| Aarylan<br>F show<br>ed at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ō              | Maryland Anne Ar                                                                                            | undel                                                            |                        | enton                                                                           |                                           |                                         |                                    |                               | 1 □ Yes 2 X No                               |
| the N<br>28a-f<br>notifie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Director       | 10e. Street and Number                                                                                      |                                                                  |                        | 10f. Zip Code                                                                   |                                           | Т                                       | 10g. Citizen of V                  | What Country                  | y?                                           |
| h with<br>3a or<br>st be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | a Di           | 725 Chapelgate D                                                                                            | rive                                                             |                        | 211                                                                             | 13                                        |                                         | G                                  | German                        | y                                            |
| ems 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Funeral        | 11. Marital Status                                                                                          | 12. Was Decedent I<br>Armed Forces?                              |                        | 13. Was Decedent of H                                                           | lispanic Origin? (S<br>an, Mexican, Puert | pecify Yes or No<br>to Rican, etc.)     | - 14. Rac                          | e - Americar<br>ck, White, et | n Indian,                                    |
| be filed within 72 hours after death with the Maryland tat Hygiene.  Adother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | þ.             | 1 ☐ Never Married 2 [X] Married<br>3 ☐ Widowed 4 ☐ Divorced                                                 | 1  Yes 2  1 If Yes, Give Year or Dates:                          | 10                     | 1 ☐ Yes 2 📉 No                                                                  | Specify:                                  |                                         | Specify                            | T 71                          |                                              |
| 72 h<br>"natu<br>dical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Completed      | 15. Decedent's Ed<br>(Specify only highest gra                                                              | lucation<br>de completed)                                        | 16a                    | . Decedent's Usual Occup<br>(Give kind of work done<br>life. DO NOT use retire. | pation<br>during most of wor              | rking                                   | 16b. Kind of Bu                    | usiness/Indu                  | stry                                         |
| within sne.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | lg l           | Elementary/Secondary (0-12)                                                                                 | College (1-4or 5                                                 | +>                     |                                                                                 | •                                         |                                         |                                    | Uomo                          |                                              |
| filed Hygie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ပိ             | 12th 17. Father's Name (First, Middle, Last)                                                                |                                                                  |                        | Homemak                                                                         | 18. Mother's Nan                          | ne (First, Middle,                      |                                    | Home<br>ne)                   |                                              |
| ld be<br>lental<br>ked o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | To Be          | Rudo1ph                                                                                                     |                                                                  |                        |                                                                                 | Char                                      | lotte Da                                | aniel                              |                               |                                              |
| shou<br>and N<br>s mar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | -              | 19a. Informant's Name/Relationship (                                                                        |                                                                  |                        | o. Mailing Address (Street                                                      |                                           |                                         |                                    |                               | ,                                            |
| and 2<br>salth and 27 ls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | Thomas Steuart De                                                                                           | acon/ Hust                                                       |                        | '25 Chapelga                                                                    |                                           |                                         |                                    |                               |                                              |
| Jes 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | 20a. Method of Disposition 1  ☐ Bunial 2 ☐ Cremation 3 ☐                                                    | Removal from State                                               | 20b. Place o<br>cemete | of Disposition (Name of<br>ery, crematory or other pla                          |                                           | Date                                    | 20c. Location -                    | City or Tow                   | n, State                                     |
| Pag<br>tment<br>tant:<br>jury c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 4 Donation 5 ☐ Other (Specification 5                                                                       | y)                                                               | MD Vet                 | terans Cemet                                                                    |                                           | 3/08                                    | Crowns                             |                               |                                              |
| permit. Pages 1 and 2 should be filed within 72 hou Department of health and Mental Hygiene. Important: If Item 27 Is marked other than "natura any Injury or other traumatic event, the Medical Eonce.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | 21. Signature of Funeral Service Licer                                                                      | isee                                                             |                        | 22. Name and Addre                                                              |                                           |                                         |                                    |                               |                                              |
| 202 10 01                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | 23a Part1. Enter the disease, or com                                                                        | plications that caused                                           | the death. Do          | 2973 Solor                                                                      |                                           |                                         |                                    | _                             | 21037<br>Approximate                         |
| Dhusisian                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final       | one cause on each lir                                            | ie.                    |                                                                                 |                                           | o or roophutory a                       |                                    |                               | nterval Between<br>Onset and Death           |
| Physician<br>/Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | disease or condition<br>resulting in death)                                                                 | a. Due to (or as                                                 | a consequence          | ancer                                                                           |                                           |                                         |                                    |                               | <del></del>                                  |
| Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                |                                                                                                             | b                                                                |                        | ,                                                                               |                                           |                                         |                                    |                               |                                              |
| 7 #                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as                                                    | a consequence          | of):                                                                            |                                           |                                         |                                    |                               |                                              |
| icate be executed<br>physician and<br>the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last                                     | c                                                                |                        |                                                                                 |                                           |                                         |                                    |                               |                                              |
| be exician a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                | resulting in death) East                                                                                    | Due to (or as                                                    | a consequence          | of):                                                                            |                                           |                                         |                                    |                               |                                              |
| ificate be executed<br>g physician and<br>as the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | edical         | •                                                                                                           | d                                                                |                        |                                                                                 |                                           |                                         |                                    |                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | IF FEMALE:<br>23b. Was decedent pregnant                                                                    | 23c. If yes, outcome                                             |                        |                                                                                 |                                           |                                         | 23d. Da                            | te of delivery                | v                                            |
| The law requires that the death cert ite has been signed by the attending age 2 should be detached for use                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Physician/M    | in the past 12 months?                                                                                      | 1□Live birth<br>4□Pregnant at                                    |                        | h 3 □Ectopic pregnand<br>5 □ Other (specify) _                                  | у                                         |                                         |                                    |                               | )ay Year                                     |
| that the de<br>led by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | hys            | 9 □Unknown                                                                                                  | 9□ Unknown                                                       |                        |                                                                                 |                                           |                                         |                                    |                               |                                              |
| gned<br>gned                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | by P           | Part II. Other significant conditions of                                                                    | ontributing to death b                                           | ut not resulting i     | n the underlying cause give                                                     | ven in Part I.                            |                                         |                                    |                               | cause of death?                              |
| w requires<br>been signe<br>should be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | COFU                                                                                                        |                                                                  |                        |                                                                                 |                                           | 12                                      | Ýes 2□ No                          | 3 Probal                      | bly 4 Unknown                                |
| law r<br>nas be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Completed      |                                                                                                             |                                                                  |                        |                                                                                 |                                           | 24a. Was<br>autoj                       | psy                                | prior to comp                 | sy findings available<br>pletion of cause of |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Con            |                                                                                                             |                                                                  |                        |                                                                                 |                                           | 1 Yes                                   |                                    | death?<br>1 ☐ Yes 2           | P□ No                                        |
| sician: Th<br>certificate<br>rector, pag                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Be             | 25. Was case referred to medical examiner?                                                                  | Hospital:                                                        |                        | Ott                                                                             | 205                                       | ath (Check only o                       |                                    |                               |                                              |
| Physical dispersion of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the standing of the sta | . To           | 1 Yes 2 No 27. Manner of Death                                                                              | 28a. Date of Inju                                                | ry 28b.                | Time of 28c. Inju                                                               | 4 LI Nursing F                            | fome 5 ☐ Resi                           | dence 6 ∐Oth<br>how injury occur   |                               | -                                            |
| Attending Physician: r death. ector: After this certific. by the funeral director,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | tion           | 1 ☑ Natural 5 ☐ Pending<br>2 ☐ Accident investigation                                                       | (Month, Da                                                       | Year)                  |                                                                                 | rƙ?<br>]Yes 2 ∐ No                        |                                         |                                    |                               |                                              |
| l or Attend<br>after death<br>Director: ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ifica          | 3 Suicide 6 Could not be determined                                                                         | 28e. Place of injuding, et                                       | ury - At home, fa      | arm, street, factory, office                                                    |                                           | 28f. Location (:<br>City or To          | Street and Numb                    | ber or Rural                  | Route Number,                                |
| tal or rs after ai Dir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Certification: | 4_1101110000                                                                                                |                                                                  | o. (Opcony)            |                                                                                 |                                           | Only of 100                             | mi, Glale)                         |                               |                                              |
| To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the ft                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | edical         | 29a. Certifier 1 ☐ Certifying Ph<br>(Check only one) 2 ☐ Medical Exam                                       | nysician: To the best<br>miner: On the basis o<br>and manner sta | f examination a        | e, death occurred at the t<br>nd/or investigation, in my                        | ime, date and place opinion, death occi   | e, and due to the<br>urred at the time, | cause(s) and ma<br>date and place, | anner as sta<br>and due to t  | ited.<br>the cause(s)                        |
| To t<br>Within                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | M              | 29b. Signature and vitle of dertifier                                                                       | = mo                                                             |                        | 29c. Licens                                                                     | se number<br>38448                        |                                         | 29d. Date signe                    | ed (Month, D                  | ay, Year)                                    |
| 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | 30. Name and address of person who Ira Weinstein, M                                                         | ·                                                                |                        |                                                                                 | no1:- M                                   | 1                                       | 21/01                              |                               |                                              |
| Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                | 31. Date filed (Month, Day, Year)                                                                           | . ע. OUU K<br>. Registr                                          | ar's Signature         | Avenue, Anna                                                                    | ipoils, M                                 | arytand                                 | Z14UI                              |                               |                                              |
| Regist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                | FEB 1 2 200                                                                                                 | 8 Eline                                                          | · H                    | Goods                                                                           |                                           |                                         |                                    |                               |                                              |

|                                                                                                                                                                                                                                                             |                  | 1 - For State Registrar                                                 | Sta                          | te of Ma                              | aryland / I                    |                      | rtment o                            |                                |                                  | Mental Hy                       | giene<br>Reg. No.                       | 08                          | 063                          | 36                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------|------------------------------|---------------------------------------|--------------------------------|----------------------|-------------------------------------|--------------------------------|----------------------------------|---------------------------------|-----------------------------------------|-----------------------------|------------------------------|----------------------|
| 3                                                                                                                                                                                                                                                           |                  | Decedent's Name (First, Middle                                          | , Last)                      |                                       |                                |                      |                                     |                                |                                  | 2. Date of De                   | ath                                     |                             | 3. Time of                   | Death                |
| Physic<br>/Med                                                                                                                                                                                                                                              |                  | Elaine                                                                  | Ma                           | ry                                    | Dod                            | son                  |                                     |                                |                                  | Februa                          | ary <sup>Day</sup> 14                   | , Ѯӧ҇҉҇ѻӿ                   | 1850                         | ) M                  |
| Exami                                                                                                                                                                                                                                                       |                  | 4a. Facility Name (If not institution                                   |                              |                                       |                                |                      | -                                   |                                | tion of Death                    |                                 |                                         | ty of Death                 |                              |                      |
|                                                                                                                                                                                                                                                             |                  | 219 Potomac                                                             |                              |                                       |                                |                      |                                     | gerst                          |                                  |                                 |                                         | shing                       |                              |                      |
| Funeral                                                                                                                                                                                                                                                     |                  | 5. Social Security Number                                               | 6. Sex<br>1 ☐ M 2            |                                       | e (In yrs. last bi             | rthday) _<br>Yrs.    | If Under 1 Months                   |                                | nder 24 Hrs.<br>urs Min.         | 8. Date of Bir<br>(Month, Da    | th<br>ly, Year)                         | Cour                        |                              | -                    |
| Director                                                                                                                                                                                                                                                    |                  | 040-38-7495 Usual Residence of Decedent                                 |                              |                                       | 55                             | 113.                 |                                     |                                |                                  | 09/08/                          | 1952                                    | Conn                        | ecticu                       | t                    |
| yland                                                                                                                                                                                                                                                       |                  | 10a. State 10b. County                                                  |                              |                                       | 10c. City, Tow                 | n or Loc             | ation                               |                                |                                  |                                 |                                         | 1                           | 0d. Inside Cit               | y Limits             |
| Mar-fet                                                                                                                                                                                                                                                     | tor              | Maryland St. Ma                                                         | ry's                         |                                       | Califo                         | rnia                 |                                     |                                |                                  |                                 |                                         |                             | 1 🗌 Yes                      | 2 <b>∑</b> No        |
| or 28                                                                                                                                                                                                                                                       | Oire             | 10e. Street and Number                                                  |                              |                                       |                                |                      | 10f. Zip Ci                         | ode                            |                                  |                                 | 10g. Citizen of                         | What Cour                   | ntry?                        |                      |
| ath w<br>23a                                                                                                                                                                                                                                                | ral              | 23196 Shady Mil                                                         | e Driv                       | e                                     |                                |                      | 2061                                | 9                              |                                  |                                 | United                                  |                             |                              |                      |
| er de                                                                                                                                                                                                                                                       | Funeral Director | 11. Marital Status                                                      | Am                           | s Decedent E<br>ned Forces?           |                                | 13. W                | as Deceder<br>Yes, specify          | nt ol Hispan<br>Cuban, Me      | ic Origin? (Sp<br>exican, Puerto | ecify Yes or No<br>Rican, etc.) |                                         | ace - Americ<br>ack, White, |                              |                      |
| at yiellid AIA 13-0030 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. In marked other then "naturer", or fleme 23a or 28a-f show marked other then "naturer", and the multiple at a medical Examinar must be notilized at | by F             | 1 Never Married 2 Marr<br>3 Widowed 4 Divorced                          | If Y                         | ]Yes 2.[X]N<br>es, Give<br>arorDates: | 10                             | 1                    | □Yes 20                             | No Sp                          | ecify:                           |                                 | Speci                                   | ity: Whi                    | i t o                        |                      |
| 2 hou                                                                                                                                                                                                                                                       | led              | 15. Decedent                                                            | 's Education                 |                                       | 16a                            | Decede               | ent's Usual (                       | Occupation                     |                                  |                                 | 16b. Kind of 8                          |                             |                              |                      |
| Pin 7:                                                                                                                                                                                                                                                      | Completed        | (Specify only highes<br>Elementary/Secondary (0-12)                     | Ť                            | leted)<br>lege (1-4or 5               | +)                             | (Give k              | kind of work i<br>O NOT use         | done during<br>retired)        | most of work                     | ang                             |                                         |                             |                              |                      |
| d with                                                                                                                                                                                                                                                      | Son              |                                                                         |                              | 2                                     |                                | chni                 | ical I                              | 11ust                          | rator                            |                                 | Civil                                   | Servi                       | ce                           |                      |
| d be file                                                                                                                                                                                                                                                   | Be (             | 17. Father's Name (First, Middle,                                       | Last)                        |                                       |                                |                      |                                     | 18. 1                          | Mother's Nam                     | e (First, Middle                | , Maiden Suma                           | ime)                        |                              |                      |
| Meni Meni Meni Meni Meni Meni Meni Meni                                                                                                                                                                                                                     | မှ               | Richard D. Sevi                                                         |                              |                                       |                                |                      |                                     |                                |                                  | Colene_                         |                                         |                             |                              |                      |
| Vicin                                                                                                                                                                                                                                                       |                  | 19a. Informant's Name/Relations                                         |                              | •                                     | i                              |                      |                                     |                                |                                  | ral Route Numb                  |                                         |                             |                              |                      |
| C, E                                                                                                                                                                                                                                                        |                  | Richard L. Dods                                                         | on/Hus                       | band                                  | and the second second          |                      |                                     |                                | _                                | , Calif                         | ornia,<br>20c. Location                 |                             | 0619                         |                      |
| Pages<br>nent of I                                                                                                                                                                                                                                          |                  | 1 ☐ Burial 2 X Cremation                                                |                              | I from State                          | 20b. Place o                   |                      |                                     |                                | I                                |                                 |                                         | ,                           |                              | _                    |
| Dallillore, Maryiallu ZIZI<br>permit. Pages 1 end 2 should be filed within<br>Department of Health and Mental Hygiene.<br>Importent: If Item 27 is marked other then<br>eny injury or other treumatic event, the Ma<br>price.                               |                  | 4 □ Donation 5 □ Other (S)  21. Signature of Funeral Service            |                              | 15                                    | Brinst                         |                      | i-Echo<br>Name and                  |                                |                                  | 0/2008                          |                                         |                             |                              |                      |
| permit. Departrimporte                                                                                                                                                                                                                                      |                  | Kyle S. Simo                                                            | ノフ                           | M01206                                | me                             |                      |                                     |                                | pri                              | insfield<br>ad, Leo             |                                         |                             |                              |                      |
|                                                                                                                                                                                                                                                             |                  | 23a. Part 1. Enter the disease, or shock, or heart failure. List        | complications                | that caused                           | the death. Do                  | 110000               |                                     |                                | 10000                            |                                 |                                         | 11, 110                     | Approximate<br>Interval Bety | 9                    |
| Physician                                                                                                                                                                                                                                                   |                  | Immediate Cause (Final disease or condition                             | only one caus                | ibaci ili                             | 1 Luc                          | las                  | con                                 | (in                            | waln                             | ~~                              |                                         | 1                           | Onset and D                  |                      |
| /Medical                                                                                                                                                                                                                                                    |                  | resulting in death)                                                     | a                            | ue to (or as a                        | a consequence                  | of):                 | -                                   |                                |                                  | J ( C                           |                                         | - 1                         | Jm                           | my m                 |
| Examiner                                                                                                                                                                                                                                                    |                  | Sequentially list conditions,                                           | b                            |                                       |                                |                      |                                     |                                |                                  |                                 |                                         |                             |                              |                      |
| be at                                                                                                                                                                                                                                                       | Examiner         | ri any, leading to immediate cause. Enter Underlying                    |                              | lue to (or as a                       | a consequence                  | or).                 |                                     |                                |                                  |                                 |                                         |                             |                              |                      |
| ecute<br>and<br>i-tran                                                                                                                                                                                                                                      | xam              | Cause (Disease or injury that initiated events resulting in death) Last | c                            | tue to (or as a                       | a consequence                  | of\:                 |                                     |                                |                                  |                                 |                                         |                             |                              |                      |
| cate be executed physicien and the burial-transit                                                                                                                                                                                                           | 四田               |                                                                         |                              |                                       |                                | 0.,.                 |                                     |                                |                                  |                                 |                                         |                             |                              |                      |
| ficate<br>ficate                                                                                                                                                                                                                                            | edical           |                                                                         | d                            |                                       |                                |                      |                                     |                                |                                  |                                 |                                         |                             |                              |                      |
| The law requires that the death certific the law requires that the death certific ete has been signed by the ettending page 2 should be deteched for use as                                                                                                 | Physician/Me     | IF FEMALE:<br>23b. Was decedent pregnant                                |                              | es, outcome                           |                                | - 0                  |                                     |                                |                                  |                                 | 23d. D                                  | ate of delive               | ery                          |                      |
| death death death                                                                                                                                                                                                                                           | lcia             | in the past 12 months?<br>1 □ Yes 2 □ No                                | 4                            | Pregnant at                           | 2 Fetal death<br>time of death |                      | Ectopic preg<br>Other (s <i>pec</i> |                                |                                  |                                 | N                                       | fonth                       | Day Y                        | 'ear                 |
| af fhe by the steeched                                                                                                                                                                                                                                      | hys              | 9 Unknown                                                               | -                            | Unknown                               |                                |                      |                                     |                                |                                  |                                 |                                         |                             |                              |                      |
| es the                                                                                                                                                                                                                                                      | by               | Part II. Other significant condition                                    | ns contributin               | ig to death bu                        | ut not resulting i             | in the un            | derlying cau                        | sa givan in l                  | Part I.                          |                                 | obacco use cor                          |                             |                              |                      |
| Ben si                                                                                                                                                                                                                                                      | ted              |                                                                         |                              |                                       |                                |                      |                                     |                                |                                  | 10                              | Yes 2 No                                | 3   Prot                    | ably 4 □U                    | nknown               |
| law<br>nesb<br>e2st                                                                                                                                                                                                                                         | Completed        |                                                                         |                              |                                       |                                |                      |                                     |                                |                                  | 24a. Was<br>auto                | DSV                                     | prior to co                 | psy lindings a               | ivailable<br>tuse ol |
| The                                                                                                                                                                                                                                                         | S                |                                                                         |                              |                                       |                                |                      |                                     |                                |                                  | 1 ☐ Yes                         | rmed?<br>2 □ No                         | death?<br>1 ☐ Yes           | 2 🗆 No                       |                      |
| V II.                                                                                                                                                                                                                                                       | Be               | 25. Was case referred to medical examiner?                              | Hospital                     |                                       |                                |                      |                                     | Other                          |                                  | th (Check only                  |                                         |                             | cone                         | home                 |
| 2 g f la                                                                                                                                                                                                                                                    | ٠ <u>.</u>       | 1 ☐ Yes 2 ☑ No 27. Manner of Death                                      |                              | 1 U Inpatie                           |                                | utpatient<br>Time of | 3□ DOA                              | 1 4                            | ☐ Nursing Ho                     | ome 5 Resi                      | dence 6 2001<br>how injury occu         | ther (Specif                | y) 50115                     |                      |
| ding<br>th.                                                                                                                                                                                                                                                 | tion             | 1 Natural 5 Pendin<br>2 Accident investig                               | 9                            | Date of Injur<br>(Month, Day          | Year)                          | Injury               | м                                   | linjury at<br>Work?<br>1 ☐ Yes | 2 🗆 No                           |                                 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                             |                              |                      |
| Atter dea                                                                                                                                                                                                                                                   | lfica            | 3 ☐ Suicide 6 ☐ Could a                                                 | not be                       | Place of Inju                         | ıry - At home, fa              | arm, stre            | et, factory, o                      | office                         |                                  |                                 | Street and Num                          | nber or Rura                | i Route Numi                 | ber,                 |
| s efte                                                                                                                                                                                                                                                      | Certification;   | 4 Homicide                                                              |                              | building, etc                         | c. (Specity)                   |                      |                                     |                                |                                  | City or To                      | wn, State)                              |                             |                              |                      |
| To the Hospitel or Attending Physician: The law within 24 hours effer death. To the Funerel Director: Affer this certificate hes completely filled in by the funeral director, page 2                                                                       | edicai           | 29a. Certifier 1 ☐ Certifyin                                            | g Physicien:<br>Exeminer: Or | To the best of                        | of my knowledg                 | e, death             | occurred at                         | the time, da                   | ite and place,                   | and due to the                  | cause(s) and n                          | nanner as s                 | tated.                       |                      |
| the hin 24<br>the F                                                                                                                                                                                                                                         | Med              | one)                                                                    | an                           | d manner sta                          | ted.                           |                      |                                     |                                |                                  |                                 |                                         |                             |                              |                      |
| To To                                                                                                                                                                                                                                                       | 1                | 29b. Signature and title of certifier                                   | , (1                         |                                       |                                |                      | 290. 1                              | icense num                     | 1, 52                            |                                 | 29d. Date sign                          | ieu (MONTA),                | Jay, Tear)                   |                      |
| 40                                                                                                                                                                                                                                                          | +                | 20 North                                                                |                              |                                       | , ()                           |                      | 1                                   | 167                            | 060                              | 1                               | fhri                                    | -41                         | 3 20                         | 13 D                 |
| O A                                                                                                                                                                                                                                                         | L                | 30. Name and address of person                                          | who complete                 | d cause of de                         | -333                           | (Type, F             | rii)<br>[ll[                        | nn                             | edic                             | 06/                             | Sahat                                   | Ral                         |                              |                      |
| St                                                                                                                                                                                                                                                          | ate              | 31. Date filed (Month, Day, Year)                                       | - (c                         |                                       | r's Signature                  |                      | 10.3                                | V 1                            |                                  | <u> </u>                        | 1                                       | ,                           | _                            |                      |
| Regist                                                                                                                                                                                                                                                      | trar             | FEB 1                                                                   | 9 2008                       | Die                                   | er M                           |                      | BALL!                               |                                | 1+                               | fegus                           | town                                    | my                          | 151                          | 742                  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12, 2008 Physician 9:50 February Brian C. Ellis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 ☐ F 1973 Washington DC 11. 34 215 90 7766 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Prince George's Bowie Director MD 10q. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20715 3908 Croydon Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZZNo If Yes, Give Year or Dates: Black, White, etc. 11. Marital Status 1√2 Never Married 2 Married 1 ☐ Yes 2 ☑No Specify. Specify: White Saltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) ARC Program Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental Hi fitem 27 is marked oth r other traumatic even Be Eileen K. Fisher Harold A. Ellis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20715 3908 Croydon Lane Bowie, MD Eileen K. Phelps/Mother Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of harmonic line important: If ite any injury or other 1 ☐ Burial 2 2 Cremation 3 ☐ Removal from State 2/14/2008 Baltimore, MD Bayview Crematory 5-☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Beall Funeral Home Bowie, MD 6512 NW Crain Hwy. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** as a consequence of): /Medical Examiner reuman! Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as attending 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year į in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. Division or Vital Records, 3 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 performe death? 1 ☐ Yes Physician: 26. Place of Death (Check onl. one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3□ DOA 1 Tyes 1 Inpatient Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred funeral 28a. Date of Injury 28b. Time of 27. Manner of Death Hospital or Attending Pl 24 hours after death. Funeral Director: After the After 1 (Month, Day Year) Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3☐ Suicide determined 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vood 001 32. Registrar's Signatu 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

|           |                                                                                                                                                |                | For State of Maryland / Departm  State of Maryland / Departm  For State of Maryland / Departm  Certific                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ent of Health and N<br>ate of Death                                   | /lental Hygler<br>Reg. t                            | 2000                                        | 0533                                             |  |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------|--------------------------------------------------|--|
| P.        | 5%                                                                                                                                             |                | Decedent's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                       | 2. Date of Death                                    | Day Year                                    | 3. Time of Death                                 |  |
|           | Physici:<br>/Medic                                                                                                                             |                | THELMA KATHERINE FARREN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                       | FEB. 2                                              | 3 200                                       |                                                  |  |
|           | Examin                                                                                                                                         | er             | FORT WASHINGTON HOSPITAL FO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | City, Town, or Location of Death  RT WASHINGTO                        | N                                                   |                                             | GEORGE'S                                         |  |
|           | Funeral<br>Director                                                                                                                            |                | 5. Social Security Number  5. 77 − 32 − 6418  6. Sex 1 □ M 2 反 F  7. Age (In yrs. last birthday)   If Ui Mon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | hder 1 Year If Under 24 Hrs. This Days Hours Min.                     | 8. Date of Birth<br>(Month, Day, Yea<br>SEP . 15, 1 | ar) Col                                     | hplace (State or Foreiguntry) HINGTON,           |  |
|           | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Items 23a or 28a-f show<br>ha Medical Examiner must be notified at | Director       | MD PRINCE GEORGE'S ACCOKEEK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Zip Code                                                              | 100.0                                               | Citizen of What Co                          | 10d. Inside City Limit 1 □ Yes 🌂 🔣 N             |  |
|           | 3a or                                                                                                                                          |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20607                                                                 |                                                     | U.S.A                                       |                                                  |  |
| 36        | ours after death w<br>ral", or Items 23a<br>Examiner must !                                                                                    | by Funeral     | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes ❤️ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ecedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto           |                                                     | 14. Race - Amer<br>Black, White<br>Specify: | rican Indian,<br>e, etc.                         |  |
| 315-003b  | I within 72 hou<br>jiene.<br>r than "natural<br>the Medical Ex                                                                                 | Completed I    | 15 Decedent's Education 16a Decedent's                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Jsual Occupation<br>f work done during most of work<br>T use retired) | 16b.                                                | . Kind of Business/I                        | ITE<br>Industry                                  |  |
| 7         | led wii<br>lygien<br>her th<br>nt, th                                                                                                          | Con            | 10 SCHOOL  17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | BUS DRIVER                                                            | P<br>ne (First, Middle, Maid                        | UBLIC S                                     | CHOOLS                                           |  |
| yland     | should be fi<br>ind Mental H<br>s marked otl<br>umatic ever                                                                                    | To Be          | HARRY E. ROBEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | BESSI                                                                 | E E. COL                                            | COLE                                        |                                                  |  |
| Mar       | 12 sho                                                                                                                                         |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ress (Street and Number or Rui                                        |                                                     | -                                           | !ip Code)                                        |  |
| -         | es 1 and<br>of Healt<br>i item 27<br>r other 1                                                                                                 |                | DONNA RICKETT/DAUGHTER 40125  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ARMY WAY LEO (Name of or other place) MAR                             | Date 20c.                                           | Location - City or                          |                                                  |  |
| Ĕ         | nit. Page<br>artment o<br>ortant: If<br>Injury or                                                                                              |                | 4 Donation 5 Other (Specify) CEDAR HILL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | CEMETRY 1,                                                            | 200                                                 | ITLAND, N                                   | MARYLAND                                         |  |
| Baltimore | permit. Depart Import any Inj                                                                                                                  | 3 3            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | e and Address of Facility RA<br>WASHINGTON                            | YMOND FU<br>AVE. LA                                 | NL.SERV.                                    | P.A.<br>MD 20646                                 |  |
| y.        | Physician                                                                                                                                      | 13 A           | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Contro | mode of dying, such as cardiac                                        | or respiratory arrest,                              |                                             | Approximate Interval Between Onset and Death     |  |
|           | /Medical<br>Examiner                                                                                                                           |                | resulting in death)  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ,                                                                     |                                                     |                                             |                                                  |  |
|           |                                                                                                                                                | ner            | Sequentially list conditions, if only leaf to line, dict. cause. Enter Underlying Cause (Disease or injury that initiated events  b. DEHyd AT(0)  The following the conditions of the cause of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events of the cause (Disease or injury that initiated events or injury that initiated events or injury that initiated events or injury that initiated events or injury that initiated events or injury that initiated events or injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that inj |                                                                       |                                                     |                                             | un k nou                                         |  |
| ρΩ,       | ificate be executed<br>g physician and<br>as the burial-transit                                                                                | al Examiner    | Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Tailure                                                               |                                                     |                                             | un kono wa                                       |  |
| 09/89     |                                                                                                                                                | Medical        | IF FEMALE:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                       |                                                     |                                             |                                                  |  |
| C. Box    | requires that the death certific<br>een signed by the attending p<br>nould be detached for use as                                              | Physician/M    | 23b. Was decedent pregnant in the past 12 months?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ic pregnancy<br>r (specify)                                           |                                                     | 23d. Date of deli<br>Month                  | livery<br>Day Year                               |  |
| rds, P.   | quires that the de<br>n signed by the a<br>uld be detached f                                                                                   | þ              | Part II. Other significant conditions contributing to death but not resulting in the underlying to Death Disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                       | 23e. Did tobacc                                     |                                             | the cause of death?                              |  |
| Hecord    | stcian: The law require<br>certificate has been sig<br>irector, page 2 should b                                                                | Completed      | Lung CANCER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                       | 24a. Was an autopsy performed                       | ? death?                                    | utopsy findings availab<br>completion of cause o |  |
| Ital      | cian:<br>ertifice<br>ctor, p                                                                                                                   | Be C           | 25. Was case referred to medical examiner?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                       | th (Check only one)                                 |                                             |                                                  |  |
| 0         | this ald                                                                                                                                       | 은              | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                       | ome 5 Residence                                     |                                             | cify)                                            |  |
|           | Ing<br>Affe<br>une                                                                                                                             | tion:          | 27. Manner of Death  1 Adural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury  (Month, Day Year)  M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No                             | 28d. Describe how in                                | njury occurred                              |                                                  |  |
| DIVISION  | il or Attending<br>after death.<br>I Director: After<br>d in by the fune                                                                       | Certification: | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, fa building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | otory, office                                                         | 28f. Location (Street<br>City or Town, St           |                                             | ural Route Number,                               |  |
|           | Hospita<br>4 hours<br>Funeral<br>tely filled                                                                                                   | edical Co      | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occur and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                       |                                                     |                                             |                                                  |  |
|           | To the within 2 To the complet                                                                                                                 | Me             | 29b. Signature and title of extifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 29c. License number                                                   | 29d.                                                | Date signed (Mont                           | h, Day, Year)                                    |  |

State

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

611mer Joseph

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|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                     |                                                                                                                                                                             |                  | 1- For AMEND#8, 16A Per FH State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                     |                                                                                                                                                                             |                  | Reg. No.  1. Decedent's Name (First, Middle, Last)  2. Date of Death  2. Date of Death  3. Time of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 8                   | Physici                                                                                                                                                                     |                  | Month Day Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 4<br>10.00<br>10.00 | /Medio<br>Examin                                                                                                                                                            |                  | Joseph R Gilmer  4b. City, Town, or Location of Death  4c. County of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                     |                                                                                                                                                                             |                  | Baltimore washington Medical center Gien Burnie Anne Arundel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                     | Funeral                                                                                                                                                                     |                  | 5 Social Security Number 6 Sate 7 Age (In virs last hirthday) If Under 1 Year   If Under 24 Hrs.   8 Date of Birth   9 Birthplace (State or Foreign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                     | Director                                                                                                                                                                    |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                     | land<br>ow                                                                                                                                                                  |                  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                     | Mary<br>Fled a                                                                                                                                                              | to               | Maryland Anne Arundel Glen Burnie 1□Yes 2MNo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                     | th the                                                                                                                                                                      | )irec            | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                     | be filed within 72 hours after death with the Maryland ital Hygiene.<br>Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Funeral Director | 466 Glen Mar Rd. Apt A2 21061 USA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                     | er dea                                                                                                                                                                      | nue              | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 36                  | rs afte                                                                                                                                                                     | y F              | 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes of Year or Dates: 1 Yes 2 No Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify |
| 21215-0036          | 2 hou<br>atura<br>cal E                                                                                                                                                     | Completed by     | 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 215                 | hin 7;<br>an "n<br>Medi                                                                                                                                                     | ple              | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                     |                                                                                                                                                                             | Sol              | 12th 0 Buter Buyer Crownsville Hospita                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| nd                  | should be filed<br>nd Mental Hyg<br>marked other<br>matic event, t                                                                                                          | Be               | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 3                   | d 2 should be<br>th and Mental<br>7 Is marked o<br>traumatic eve                                                                                                            | ို               | Frederick Gilmer Sr Katherine Pack                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Maryland            | d 2 s<br>th ar<br>7 is<br>trau                                                                                                                                              |                  | 19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061  Brenda Hillard (Sister)  466 Glen Mar Rd. Apt A2 Glen Burnie, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <u>6</u>            | Heg<br>Heg<br>the                                                                                                                                                           |                  | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 9                   | Pages<br>nent of<br>int: If Its<br>iry or o                                                                                                                                 |                  | 1□Burial 2 TyCremation 3 □Removal from State 4□Donation 5□Other (Specify)  Metro Crematory 2-12-08  Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Baltimore,          | permit. Pag<br>Department<br>Important: I<br>any injury o                                                                                                                   |                  | 21. Signature of Funeral Service Licensee Aname Cooks of Scill Ons Mortuary, F.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 8                   | 8 2 5 8                                                                                                                                                                     |                  | Jarry D. Reese moo483 821 West St. Annapolis, Md. 21401                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| i e                 |                                                                                                                                                                             |                  | 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 8                   | Physician                                                                                                                                                                   |                  | Immediate Cause (Final disease or condition resulting in death)  a. Hyporic Retor Odory Farlure  where the conset and Death Way.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                     | /Medical<br>Examiner                                                                                                                                                        |                  | (or as a consequence 1):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                     | (E) (E)                                                                                                                                                                     | <u>-</u>         | Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequents of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                     | uted<br>d<br>ansit                                                                                                                                                          | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  C. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| ó                   | eath certificate be executed<br>attending physician and<br>for use as the burial-transit                                                                                    |                  | resulting in death) Last  Du to or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 3760,               | ate be<br>nysicii<br>he bu                                                                                                                                                  | ical             | a Marpia Obesity Jus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 89 x                | ertific<br>ling p                                                                                                                                                           | Mec              | IF FEMALE:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Вох                 | attend<br>for us                                                                                                                                                            | ian/             | 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of delivery Month Day Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| o.                  | that the dened by the a                                                                                                                                                     | Physician/Medi   | 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <u>α</u>            | that<br>red by<br>deta                                                                                                                                                      |                  | Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| rds                 | quires<br>an signa<br>uld be                                                                                                                                                | ed by            | Big Detes Hypertension Cor VImorale 1 yes 2 No 32 Probably 4 Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| or Vital Records,   | The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as the                                                   | Completed        | 24a. Was an 24b. Were autopsy findings available                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Ř                   | (0 0                                                                                                                                                                        | mo;              | autopsy prior to completion of cause of performed? death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| /ita                | sician: Th<br>certificate<br>rector, pag                                                                                                                                    | Be (             | 25. Was case referred to medical examiner? 26. Place of Death Check onlone                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| or                  | is is                                                                                                                                                                       | 으                | 1 Yes 27 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Magner of Feath 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| OU                  | ding<br>h.<br>After<br>funer                                                                                                                                                | tion             | 27. Magner of Teath 28a. Øate of Injury 1 Natural 5 □ Pending (Month, Day Year) 1 Natural 5 □ Pending (Month, Day Year) 1 □ Ves 2 □ No  2 Accident investigation 28a. Øate of Injury 1 Natural 28b. Time of Injury at Work? 1 □ Yes 2 □ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Division            | Attending<br>r death.<br>ector: After<br>by the fune                                                                                                                        | fica             | 3 Suicide 4 Described  6 Could not be determined  28e. Place of injury. At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Ö                   | tal or<br>rs afte<br>al Dir                                                                                                                                                 | Certification:   | 4 ☐ Homicide building, etc. (Specify)  City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                     | Hospital                                                                                                                                                                    |                  | 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                     | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral                                 | Medical          | one) and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>\</b>            | 5 4 8 H                                                                                                                                                                     | -                | Mario Palvino MD D0032744 Felacina 9 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                     |                                                                                                                                                                             |                  | 30. Natine and address of person who completed cause of death (Item 23a) (Type, Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 1                   | e CH                                                                                                                                                                        |                  | MARIA GAVIRIA MD 301 Horatal Dr Glen Durnie MP 21061                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 1                   | Sta                                                                                                                                                                         |                  | 31. Date filed (Month, Day, Year) FEB 1 2 2008  32. Segistrar's Signature  Spark                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| DHI                 | Registr<br>MH 17 Bev 1/20                                                                                                                                                   |                  | LED - A LOOP JAMES D. JAMES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 21 **Physician** Vera Hege February 2008 4:12 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mennonite Fellowship Home Hagerstown Washington 8. Date of Birth (Month, Day, June 27 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 6. Sex **Funeral** 1927 Months Maryland 1 ☐ M 2 K F 220-34-0946 80 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits a or 28a-f show t be notified at 10b. County MD. Washington 1 ☐ Yes 2 No Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. and If item 2 15 marked other than "natural", or items 23a or any or other traumaft event, the Medical Ex miner must be r 12349 Huyett Lane 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2 ☑ No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Completed by 3₺ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jonas E. Horst Nancy M. Horst ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Burkholder/Nephew 13846 Midvale Rd. Waynesboro, PA. 17268 20b. Place of Disposition (Name of cemetery, crematory or other place)
Reiff Mennonite Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/25/08 Cearfoss, MD. 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zimmerman And Son Funeral Home 45 S. Carlisle St. Greencastle, Pa. 17225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** schere /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 2 No 3 Probably 4 Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed?
Yes 2 No page 2 s certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ۴ 1 ☐ Inpatient After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death

To the Funeral Director; of completely filled in by the f 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number 30. Name andaddre leted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State 2008 Registrar

**Physici** /Media Examin

**Funeral** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madrica Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, State Registrar

| _                                       | For State Of Was yield / State Registrar                                                                                                               |            | ificate o               |                                   |           | Re                              | g. No.                 | UUC                       | Ub             | 34                        |
|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------------------------|-----------------------------------|-----------|---------------------------------|------------------------|---------------------------|----------------|---------------------------|
| n                                       | 1. Decedent's Name (First, Middle, Last)  CLRRIC HART                                                                                                  |            |                         |                                   |           | Date of Deatl     Month         | Day                    | Year                      |                | of Death<br><b>20 P</b> M |
| al .                                    | 4a. Facility Name (If not institution, give street and number)                                                                                         | 1          | 4h City Town            | or Location of                    |           | RAWARS                          |                        | nunty of Dea              | •              | (                         |
| r                                       | BALTIMORE - WASHINGTON HERICAL CEN                                                                                                                     | 1          |                         | SIURUUB.                          |           |                                 | AN'                    |                           | NDEC           |                           |
|                                         | 5. Social Security Number 6. Sex 7. Age (In yrs. last b                                                                                                |            | If Under 1 Ye           | ar [ If Under 2                   |           | 8. Date of Birth                |                        | 9. Bir                    | thplace (State | e or Foreigi              |
|                                         | 049-52-2883 1□M ★F 56  Usual Residence of Decedent                                                                                                     | Yrs.       | Months Day              | rs Hours                          | Min.      | (Month, Day,<br>Aug 12          | 195                    | 1 Cor                     | nnecti         | icut                      |
|                                         | 10a. State 10b. County 10c. City, Tox                                                                                                                  | wn or Loc  | ation                   |                                   |           |                                 |                        |                           | 10d. Inside    | City Limits               |
| ctor                                    | Maryland Anne Arundel Ode                                                                                                                              | nton       | 1                       |                                   |           |                                 |                        |                           | 1 □ Y€         | es 2 <b>∏X</b> ∫o         |
| ě                                       | 10e. Street and Number                                                                                                                                 |            | 10f. Zip Cod            | е                                 |           | 11                              | g. Citizer             | n of What Co              | ountry?        |                           |
| a                                       | 610 Rolling Hill Walk #303                                                                                                                             |            | 21                      | 113                               |           |                                 | U                      | SA                        |                |                           |
| ne                                      | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?                                                                                         | 13. W      | as Decedent             | f Hispanic Orig<br>uban, Mexican, | in? (Spec | cify Yes or No-                 | 14                     | Race - Ame<br>Black, Whit | erican Indian, |                           |
| y Fu                                    | 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1976-9                                                                        | 1          | □Yes 2☐X                |                                   |           | ,                               | Sį                     |                           | lack           |                           |
| ted k                                   |                                                                                                                                                        | a. Decede  | ent's Usual Oc          | cupation                          | of workin | g                               | 16b. Kind              | of Business               |                |                           |
| Be Completed by Funeral Director        | Elementary/Secondary (0-12) College (1-4or 5+)                                                                                                         |            |                         | ne during most<br>ired)           |           | 1                               | E+                     | Coor                      | ge Mea         | o 5 c                     |
| Š                                       | 12th 2yrs Ad  17. Father's Name (First, Middle, Last)                                                                                                  | WIIII      | ISTIAT                  | or Spe                            |           | (First, Middle, I               |                        |                           | Je neo         | aue_                      |
| To Be                                   | Gilbert Marvland Blakes                                                                                                                                |            |                         | Emm                               | na C      | lark                            |                        |                           |                |                           |
| _                                       | 1 1 21                                                                                                                                                 |            |                         |                                   |           | Route Number                    |                        |                           |                | C                         |
|                                         |                                                                                                                                                        |            | Starr<br>ition (Name of |                                   |           | aven,                           |                        |                           | Town, State    | 1100                      |
|                                         | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State                                                                                                        | tery, crem | atory or other  Vete    | olace)                            |           |                                 |                        |                           | lle, l         | Md.                       |
|                                         | 4 □ Donation 5 □ Other (Specify) I*Id I'Y  21. Signature of Funeral Service Licensee                                                                   |            |                         |                                   |           | Mortu                           |                        |                           |                |                           |
|                                         | Lam of Reese MO0485                                                                                                                                    |            |                         |                                   |           | apolis                          |                        |                           |                |                           |
|                                         | 23a. Part1. Enter the disease, or complications that caused the death. Do                                                                              | o not ente | er the mode of          | dying, such as                    | cardiac o | r respiratory arr               | est,                   |                           | Approxin       | nate<br>Between           |
|                                         | shock, or heart failure. List only one cause on each line. Immediate Cause (Final                                                                      | 14.00      |                         |                                   |           |                                 |                        |                           | Onset an       | nd Death                  |
|                                         | disease or condition resulting in death)  a. Due to (or as a consequence                                                                               |            | o Ky                    |                                   |           |                                 |                        |                           | ~ 0k           | 77                        |
|                                         | Sequentially list conditions  b. RESPIRATORY                                                                                                           | 94         | TZZZ                    |                                   |           |                                 |                        |                           | 2 DA           | 245                       |
| ner                                     | Sequentially list conditions, if any, feating to finite date cause. Enter Underlying                                                                   | 0.00       |                         |                                   |           |                                 |                        |                           |                |                           |
| am                                      | that initiated events c.                                                                                                                               |            |                         |                                   |           |                                 |                        |                           | 13 46          | <b>LAS</b>                |
| al Ex                                   | resulting in death) Last Due to (or as a consequence                                                                                                   | e of):     |                         |                                   |           |                                 |                        |                           |                |                           |
| Completed by Physician/Medical Examiner | a                                                                                                                                                      |            |                         |                                   |           |                                 |                        |                           |                |                           |
| N/                                      | IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea                                                  | ath 3□     | Ectopic pregn           | ancv                              |           |                                 | 23                     | d. Date of de             | -              |                           |
| Cia                                     | In the past 12 months?  4□Pregnant at time of death                                                                                                    |            | Other (specify          |                                   |           |                                 |                        | Month                     | Day            | Year                      |
| hys                                     | 9 ☐ Unknown                                                                                                                                            |            |                         |                                   |           |                                 |                        |                           |                | _                         |
| ΣP                                      | Part II. Other significant conditions contributing to death but not resulting                                                                          | in the un  | iderlying cause         | given in Part I.                  |           | 23e. Did to                     | bacco use              |                           | to the cause   |                           |
| g                                       | 23738410                                                                                                                                               |            | ·                       |                                   |           | 1 🗆 Y                           | es 2 🔀                 | No 3□F                    | Probably 4     | Unknow                    |
| olet                                    |                                                                                                                                                        |            |                         |                                   |           | 24a. Was a                      |                        | 24b. Were a               | autopsy findin | igs availab               |
| E                                       |                                                                                                                                                        |            |                         |                                   |           | autop<br>perfor<br>1⊟ Yes       | med?                   | death?                    |                | or cause of               |
| e<br>C                                  | 25. Was case referred to medical                                                                                                                       |            |                         | 26. Place                         | of Death  | (Check only or                  |                        |                           |                |                           |
| To Be                                   | examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/0                                                                                                    | Outpatien  | t 3 DOA                 | Other: 4 🗆 Nu                     | rsina Ho  | ne 5 ☐ Resid                    | ence 6                 | □Other (Sp                | ecify)         |                           |
| -                                       | 27. Manner of Death 28a. Date of Injury 28b                                                                                                            | o. Time of |                         | njury at<br>Work?                 |           | 28d. Describe h                 |                        |                           |                |                           |
| tio                                     | 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation                                                                                         | Injury     |                         | vvork?<br>1 ∐ Yes 2 ∐ I           | No        |                                 |                        |                           |                |                           |
| ertifica                                | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)                                                       | farm, stre | eet, factory, of        | ice                               | 1         | 28f. Location (S<br>City or Tow | treet and<br>n, State) | Number or I               | Rural Route N  | Number,                   |
| Medical Certification:                  | 29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowlec 2 Medical Examiner: On the basis of examination and manner stated. |            |                         |                                   |           |                                 |                        |                           |                | se(s)                     |
| Mec                                     | 29b. Signature and title of certifier                                                                                                                  |            | 29c. Lie                | ense number                       |           | :                               | 29d. Date              | signed (Mo                | nth, Day, Yea  | 1 <i>r</i> )              |
|                                         | Discours and Chinques NO                                                                                                                               |            | 00                      | 16230                             | 41        |                                 | FEBI                   | VAAUS                     | 6,200          | 80                        |
| -                                       | 30. Name and address of person who completed cause of death (Item 23s                                                                                  |            |                         |                                   |           |                                 |                        |                           |                |                           |
|                                         | CUILLERMO JOSÉ GIANERECO 30                                                                                                                            | 1 1400     | JATIFE                  | D C JUING                         | 43)       | BURNIE                          | WD 3                   | rorel                     |                |                           |
| te<br>ar                                | 31. Date filed (Month, Day, Year) FEB 1 2 2008 32. Segistrar's Signature                                                                               | . 1        | restes                  |                                   |           |                                 |                        |                           |                |                           |
|                                         |                                                                                                                                                        | - 12       |                         |                                   |           |                                 |                        |                           |                |                           |

|          |                                                                                                                                                                                                                                                                                                  |                | 1 - State of Maryland / De State of Maryland / De Registrar                                                                                                                               | epartment of F<br>Certificate of                                         |                               |                               | 'gien<br>Reg. N      | - Z 11 11 E                   | 06342                                               |
|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------|-------------------------------|----------------------|-------------------------------|-----------------------------------------------------|
| 1 5      | Physicia                                                                                                                                                                                                                                                                                         | 推奏             | Decedent's Name (First, Middle, Last)                                                                                                                                                     |                                                                          |                               | 2. Date of De                 |                      | ay Year                       | 3. Time of Death                                    |
|          | /Medic                                                                                                                                                                                                                                                                                           |                | Talbot Harding                                                                                                                                                                            |                                                                          |                               | Februa                        | ry                   | 15, 2008                      | <del>_</del> _                                      |
|          | Examin                                                                                                                                                                                                                                                                                           | er             | 4a. Facility Name (If not institution, give street and number)                                                                                                                            |                                                                          | or Location of Death          |                               |                      | c. County of Dea              |                                                     |
| -        | Funeral                                                                                                                                                                                                                                                                                          |                | St. Mary's Nursing Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birth)                                                                                                   |                                                                          | If Under 24 Hrs.              | 8. Date of Bir                | rth                  | t. Mary 9. Bird               | Shplace (State or Foreign ountry)                   |
| ĥ        | Director                                                                                                                                                                                                                                                                                         |                | 273-07-2551 1 M 2 ☐ F 96 Yr  Usual Residence of Decedent                                                                                                                                  | Months Days                                                              | Hours Min.                    | (Month, Da<br>01/17/          |                      | 2 Ohi                         |                                                     |
|          | yland<br>now<br>at                                                                                                                                                                                                                                                                               |                | 10a. State 10b. County 10c. City, Town of                                                                                                                                                 | r Location                                                               |                               |                               |                      |                               | 10d. Inside City Limits                             |
|          | death with the Maryland<br>ms 23a or 28a-f show<br>r must be notified at                                                                                                                                                                                                                         | Director       | Maryland St. Mary's Leonardt                                                                                                                                                              | own                                                                      |                               |                               |                      |                               | 1X Yes 2 No                                         |
|          | with the                                                                                                                                                                                                                                                                                         |                | 10e. Street and Number                                                                                                                                                                    | 10f. Zip Code                                                            |                               |                               | Ü                    | Citizen of What Co            |                                                     |
|          | ns 23                                                                                                                                                                                                                                                                                            | Funeral        | 22680 Cedar Lane Court  11. Marital Status 12. Was Decedent Ever in U.S.                                                                                                                  | 20650  13. Was Decedent of H If Yes, specify Cub                         | Hispanic Origin? (Sp          |                               |                      | ted Stat                      |                                                     |
| 0000     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Fur         | Armed Forces?  1 ☐ Never Married 2 ☐ Married   1 ☒ Yes 2 ☐ No   If Yes, Give   Year or Dates:                                                                                             | If Yes, specify Cub<br>1 ☐ Yes 2 🕅 No                                    |                               | Rićan, etc.)                  |                      | Black, White Specify:         |                                                     |
| 5        | 72 ho<br>natur<br>dical I                                                                                                                                                                                                                                                                        | eted           | 15. Decedent's Education 16a. D (Specify only highest grade completed) ((                                                                                                                 | ecedent's Usual Occup<br>Give kind of work done<br>fe. DO NOT use retire | pation<br>during most of work | ing                           | 16b.                 | Kind of Business              |                                                     |
| V        | within<br>ene.<br>than "                                                                                                                                                                                                                                                                         | Completed      | Elementary/Secondary (0-12)   College (1-4or 5+)                                                                                                                                          | fe. DO NOT use retire<br>Lic Relatio                                     |                               |                               | Nor                  | wspaper                       |                                                     |
| 7        | Hygid<br>Hygid<br>Sther<br>ent, th                                                                                                                                                                                                                                                               |                | 17. Father's Name (First, Middle, Last)                                                                                                                                                   | LIC RELACIO                                                              | 18. Mother's Name             |                               |                      |                               |                                                     |
| <u>a</u> | Ald be<br>Alental<br>rked o                                                                                                                                                                                                                                                                      | To Be          | Richard Talbot Harding                                                                                                                                                                    |                                                                          | Della Ele                     | ouse Pu                       | rce                  | 11                            |                                                     |
| <u>a</u> | 2 short and his ma                                                                                                                                                                                                                                                                               |                | 19a. Informant's Name/Relationship (Type. Print) 19b. M                                                                                                                                   | lailing Address (Street                                                  | and Number or Rur             | al Route Numb                 | er, City             | or Town, State,               | Zip Code)                                           |
| ≥<br>15  | l and<br>Health<br>m 27<br>her tr                                                                                                                                                                                                                                                                |                |                                                                                                                                                                                           | Turnberry isposition (Name of                                            |                               | ndsor,                        |                      | 06095                         | Town Chata                                          |
| 5        | ages int of h                                                                                                                                                                                                                                                                                    |                | 1 ☐ Bunal 2 X Cremation 3 ☐ Removal from State                                                                                                                                            | crematory or other pla                                                   | ice)                          |                               |                      | Location - City or            |                                                     |
| Daltimor | artme<br>artme<br>ortant<br>injury                                                                                                                                                                                                                                                               |                | 4 □ Donation 5 □ Other (Specify) Brinsfi  21. Signature of Experis Service Ligenses                                                                                                       | eld-Echols 22. Name and Addre                                            | ess of Facility               | 8/2008                        |                      | rlotte I                      |                                                     |
| Ď        | permi<br>Depari<br>Impor<br>any ir                                                                                                                                                                                                                                                               |                | Edward N. Brinsfield, Jr. M00052                                                                                                                                                          | 22. Name and Addre<br>22955 Ho11                                         | Bri<br>ywood Roa              | nsfleto<br>d, Leor            | ı Fu<br>nard         | ineral Ho<br>Itown, MI        | ome, P.A.<br>20650                                  |
| ľ        | 2.0                                                                                                                                                                                                                                                                                              |                | 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.                                                   | enter the mode of dyi                                                    | ng, such as cardiac           | or respiratory a              | arrest,              |                               | Approximate<br>Interval Between<br>Onset and Death  |
|          | Physician<br>/Medical                                                                                                                                                                                                                                                                            |                | Immediate Cause (Final disease or condition resulting in death)  a. Respiratory Fai                                                                                                       |                                                                          |                               |                               |                      |                               | Hours                                               |
|          | Examiner                                                                                                                                                                                                                                                                                         |                | Due to (or as a consequence of b. Congestive Hear                                                                                                                                         |                                                                          |                               |                               |                      |                               | 1 Week                                              |
| 2        | · 参湾                                                                                                                                                                                                                                                                                             | Jer            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying                                                                                                        | :                                                                        |                               |                               |                      |                               | 1 WCCR                                              |
|          | ecutec<br>and<br>-transi                                                                                                                                                                                                                                                                         | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last c. Cardiomyopathy  Due to (or as a consequence of                                                                 | •                                                                        |                               |                               |                      |                               | 1 Year                                              |
| 00/00    | ificate be executed<br>g physician and<br>as the burial-transit                                                                                                                                                                                                                                  | edical E       | d. Coronary Artery                                                                                                                                                                        |                                                                          |                               |                               |                      |                               | Years                                               |
|          | ertifica<br>ling ph                                                                                                                                                                                                                                                                              |                | IF FEMALE:                                                                                                                                                                                |                                                                          |                               |                               |                      |                               |                                                     |
| O. DOX   | w requires that the death certif<br>been signed by the attending<br>should be detached for use as                                                                                                                                                                                                | Physician/M    | 23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown | 3 ☐ Ectopic pregnanc<br>5 ☐ Other (specify) _                            | У                             |                               |                      | 23d. Date of de<br>Month      | livery<br>Day Year                                  |
| ŗ        | that in the properties details                                                                                                                                                                                                                                                                   |                | Part II. Other significant conditions contributing to death but not resulting in t                                                                                                        | ne underlying cause giv                                                  | ven in Part I.                | 23e. Did                      | tobacco              | o use contribute to           | the cause of death?                                 |
| cords    | equires<br>en sign                                                                                                                                                                                                                                                                               | ed by          | C.O.P.D.                                                                                                                                                                                  |                                                                          |                               | 1 🗆                           | Yes                  | 2 <b>X</b> No 3□P             | robably 4  ☐Unknown                                 |
| 1600     | The law re<br>ite has be                                                                                                                                                                                                                                                                         | Completed      |                                                                                                                                                                                           |                                                                          |                               | 24a. Was                      | DSV                  | prior to                      | utopsy findings available<br>completion of cause of |
| ומו      | n: Th<br>ficate<br>rr, pag                                                                                                                                                                                                                                                                       |                | 25. Was case referred to medical                                                                                                                                                          |                                                                          |                               | perf<br>1□ Yes                |                      | ? death?<br>No 1 ☐ Yes        | 2 □ No                                              |
|          | /sicia<br>s certi                                                                                                                                                                                                                                                                                | To Be          | examiner?  1 Yes 2 XNo  Hospital: 1 Inpatient 2 ER/Outp                                                                                                                                   | atient 3 DOA Oth                                                         | 26. Place of Deat             |                               |                      | 6 □Other (Spe                 | ocify)                                              |
| 5        | ig Phy<br>ter this<br>neral of                                                                                                                                                                                                                                                                   |                | 27. Manner of Death 28a. Date of Injury 28b. Tir                                                                                                                                          | ne of 28c. Inju                                                          |                               | 28d. Describe                 |                      |                               | icity)                                              |
| IVISION  | tendir<br>eath.<br>or: Af<br>the fur                                                                                                                                                                                                                                                             | atio           | 2 Accident investigation                                                                                                                                                                  | M 1                                                                      | ]Yes 2 □No                    |                               |                      |                               |                                                     |
|          | or Att                                                                                                                                                                                                                                                                                           | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)                                                                        | , street, factory, office                                                |                               | 28f. Location (<br>City or To | (Street a<br>wn, Sta | and Number or R<br>ate)       | ural Route Number,                                  |
|          | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.                                                                                                          |                | 29a. Certifier 1  Certifying Physician: To the best of my knowledge,                                                                                                                      |                                                                          |                               |                               |                      |                               |                                                     |
|          | the Ho<br>hin 24<br>the Fu<br>uplete                                                                                                                                                                                                                                                             | Medical        | (Check only 2 Medical Examiner: On the basis of examination and/one) and manner stated.                                                                                                   |                                                                          |                               | rred at the time              |                      |                               |                                                     |
|          | Wit<br>To                                                                                                                                                                                                                                                                                        | 2              | 29b. Signature and title of certifier                                                                                                                                                     | 29c. Licens                                                              | 06419                         |                               |                      | Date signed (Mon $2 - 17 - 6$ |                                                     |
|          | 100                                                                                                                                                                                                                                                                                              |                | 30. Name and address of person who completed cause of death (item 23a) (T                                                                                                                 | rpe, Print)                                                              | 00717                         |                               |                      | * 1176                        | 10                                                  |
| 1        | 4                                                                                                                                                                                                                                                                                                |                | James P. Jarpoe, M.D. 2/4035 Three                                                                                                                                                        | -                                                                        | d, Hollywo                    | ood, MD                       | 20                   | 0636                          |                                                     |
|          | Sta                                                                                                                                                                                                                                                                                              | -              | 31. Date filed (Month, Day, Year)  32. Registrar's Signature                                                                                                                              | 1 65                                                                     |                               |                               |                      |                               |                                                     |
|          | Registr                                                                                                                                                                                                                                                                                          | ar             | FEB 1 9 2008                                                                                                                                                                              | ( Special                                                                |                               |                               |                      |                               |                                                     |

|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | For<br>State<br>Registrar                                                                                  | State of Maryla                                                                        |                                     | rtificate of E                                                    |                                            | -                                        | g. No. 2008                                     | 06343                                              |
|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------|--------------------------------------------|------------------------------------------|-------------------------------------------------|----------------------------------------------------|
|                                | Physici<br>/Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | Decedent's Name (First, Middle, Lateral Harold                                                             | E .                                                                                    | Н                                   | obbs                                                              |                                            | 2. Date of Death<br>Month<br>February    | 11, 2008 Year                                   | 3. Time of Death<br>9:15 P M                       |
|                                | Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | 4a. Facility Name (If not institution, give                                                                |                                                                                        |                                     | 4b. City, Town, or                                                |                                            |                                          | 4c. County of Death                             |                                                    |
|                                | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | *              | Calvert Memorial H 5. Social Security Number 6. S                                                          |                                                                                        | s. last birthday)                   | Prince From                                                       | ederick<br>If Under 24 Hrs.                | 8. Date of Birth                         | Calver 9. Birth                                 |                                                    |
|                                | Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                | 577–32–8292 Usual Residence of Decedent                                                                    | ex. 7. Age (In yr                                                                      | Yrs.                                | Months Days                                                       | Hours Min.                                 | May 23,                                  | 1927 Mas                                        | place (State or Foreign<br>intry)<br>Sachusetts    |
|                                | e Maryland<br>a-f show<br>tified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ctor           | 10a. State 10b. County Maryland Prince Ge                                                                  |                                                                                        | City, Town or Lo<br>orestvill       |                                                                   |                                            |                                          |                                                 | 10d. Inside City Limits                            |
|                                | ath with the 23a or 28                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ral Director   | 10e. Street and Number<br>3410 Springdale Aver                                                             |                                                                                        |                                     | 10f. Zip Code<br>20747                                            |                                            |                                          | g. Citizen of What Cou<br>USA                   |                                                    |
| 900                            | be filed within 72 hours after death with the Maryland stal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | by Funeral     | 11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                                 |                                                                                        |                                     | Was Decedent of His<br>If Yes, specify Cubar<br>1 ☐ Yes 2️☐ No    |                                            | ecify Yes or No-<br>Rican, etc.)         | 14. Race - Amer<br>Black, White<br>Specify: Wh  | , etc.                                             |
| 5-0                            | "natu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | letec          | 15. Decedent's Ed<br>(Specify only highest gra                                                             | ducation<br>ade completed)                                                             | 16a. Dece                           | dent's Usual Occupa<br>kind of work done d<br>DO NOT use retired) | ition<br>Juring most of worki              | ing                                      | 6b. Kind of Business/I                          | ndustry                                            |
| 712                            | within jiene.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Completed      | Elementary/Secondary (0-12)  9th                                                                           |                                                                                        | Construction                        | on                                                                |                                            |                                          |                                                 |                                                    |
| nd                             | be filed<br>ttal Hygid<br>of other<br>event, tt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | BeC            | 17. Father's Name (First, Middle, Last,                                                                    | )                                                                                      |                                     |                                                                   | 18. Mother's Name                          |                                          | laiden Surname)                                 |                                                    |
| ryla                           | 2 should be and Mental is marked o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 우              | Alfred Hobbs                                                                                               | Tire Orient                                                                            | 40h Maili                           |                                                                   |                                            | Du Long                                  | O'                                              |                                                    |
| Baltimore, Maryland 21215-0036 | D # 17 #                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                | 19a. Informant's Name/Relationship (Mary M. Taylor / Daug                                                  |                                                                                        |                                     | Sun Park La                                                       |                                            |                                          | City or Town, State, Z<br>land 2063             |                                                    |
| Jore                           | permit. Pages 1 an<br>Department of Heal<br>Important: If Item 2<br>any injury or other                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | 20a. Method of Disposition 1 ■ Cremation 3 ■                                                               | memoval nom state                                                                      |                                     | sition (Name of<br>matory or other place                          | 1                                          |                                          | 20c. Location - City or                         |                                                    |
| altin                          | nit. Parame<br>partme<br>cortant<br>injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                | 4 ☐ Donation 5 ☐ Other (Specification 21. Signature Funeral Service Licer                                  | /                                                                                      |                                     | et. Cemetery  2. Name and Addres                                  |                                            |                                          | Cheltenham, I<br>alas Funeral 1                 |                                                    |
| ă                              | permi<br>Depar<br>Impor<br>any ir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | e e            | 1 Agr 8. 14                                                                                                | ales f.                                                                                | $\epsilon$                          | 5160 Oxon Hi                                                      |                                            |                                          |                                                 |                                                    |
| П                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only                                |                                                                                        |                                     |                                                                   |                                            | or respiratory arre                      | st,                                             | Approximate<br>Interval Between<br>Onset and Death |
|                                | Physician /Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | Immediate Cause (Final disease or condition resulting in death)                                            | a ACUTE CERE                                                                           |                                     | ULAR ACCI                                                         | DENT                                       |                                          |                                                 | Onset and Death                                    |
|                                | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                | V24 5000 50 500                                                                                            | Due to (or as a cons                                                                   |                                     | N                                                                 |                                            |                                          |                                                 |                                                    |
| ę.                             | P #                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | iner           | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a cons                                                                   | equence of):                        |                                                                   |                                            |                                          |                                                 |                                                    |
|                                | xecute<br>and<br>II-trans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last                                    | c. ATHEROSCLER                                                                         |                                     | RDIOVASCU                                                         | LAR DISEA                                  | ASE                                      |                                                 |                                                    |
| 68760,                         | ificate be executed<br>g physician and<br>as the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | edical E       |                                                                                                            | _d.                                                                                    |                                     |                                                                   |                                            |                                          |                                                 |                                                    |
|                                | a g                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                | IE ECMAI C                                                                                                 | <u>.</u>                                                                               |                                     |                                                                   |                                            |                                          |                                                 |                                                    |
| .O. Box                        | that the death cert<br>led by the attending<br>detached for use a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Physician/IV   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                    | 23c. If yes, outcome pf preg<br>1 Live birth 2 Fe<br>4 Pregnant at time o<br>9 Unknown | etal death 3                        | Ectopic pregnancy Other (specify)                                 |                                            |                                          | 23d. Date of deli<br>Month                      | very<br>Day Year                                   |
| Records, P.                    | ign<br>be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | b              | Part II. Other significant conditions of END STAGE RENA                                                    |                                                                                        | esulting in the u                   | nderlying cause give                                              | n in Part I.                               |                                          | acco use contribute to<br>s 2 □ No 3 □ Pro      | the cause of death?                                |
| 900                            | aw<br>as b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ompleted       | CHRONIC OBSTRU                                                                                             | CTIVE PULMONA                                                                          | RY DISE                             | ASE                                                               |                                            | 24a. Was an                              |                                                 | topsy findings available completion of cause of    |
| E B                            | ian: The rificate hastor, page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Com            |                                                                                                            |                                                                                        |                                     |                                                                   |                                            | autopsy<br>perform<br>1∐ Yes 2           | yed? death?<br>!∐No 1 ☐ Yes                     | 2 □ No                                             |
| or Vital                       | o e e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Be             | 25. Was case referred to medical examiner? 1 ☐ Yes 2XXNo                                                   | Hospital: XXInpatient 2                                                                |                                     | ot 3DDOA Othe                                                     | 26. Place of Death                         |                                          | •                                               |                                                    |
| 0                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | n: To          | 27. Manner of Death                                                                                        | 28a. Date of Injury                                                                    | ER/Outpatier 28b. Time o            | " OLI DOX                                                         | 4 Li Nursing Ho                            | me 5 Reside<br>28d. Describe ho          | nce 6 □Other (Spec<br>w injury occurred         | cify)                                              |
| sion                           | Attending r death. sctor: After y the fune                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | atio           | 1 XIX atural 5 Pending 2 Accident investigation                                                            |                                                                                        | Injury                              |                                                                   | res 2 □ No                                 |                                          |                                                 |                                                    |
| Division                       | or Attendate death Director:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Certification: | 3 ☐ Suicide 6 ☐ Could not b determined                                                                     | 28e. Place of injury - At building, etc. (Spe                                          | home, farm, str<br>cify)            | eet, factory, office                                              |                                            | 28f. Location (Str<br>City or Town       | reet and Number or Ru<br>, State)               | ral Route Number,                                  |
|                                | To the Hospital or Al<br>within 24 hours after of<br>To the Funeral Direc<br>completely filled in by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | edical C       | 29a. Certifier 1 Certifying Pr<br>(Check only one) 2 Medical Example                                       | nysician: To the best of my k<br>miner: On the basis of exami<br>and manner stated.    | nowledge, deat<br>ination and/or in | h occurred at the tim<br>vestigation, in my op                    | ne, date and place,<br>pinion, death occur | and due to the ca<br>red at the time, da | ause(s) and manner as<br>ate and place, and due | stated.<br>to the cause(s)                         |
|                                | To the within 2 To the complet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ×              | 29b. Signature and title of certifier                                                                      | c. Sun a                                                                               | wa.                                 | 29c. License                                                      | D 506                                      | 553                                      | od. Date signed (Month<br>2/11/2008             |                                                    |
| R                              | (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) + (9) |                | 30. Name and address of person who Gyan C. Surana                                                          | MD 5851 Dea                                                                            | 1eChurc                             | hton Road                                                         | Deale Ma                                   | aryland                                  | 20751                                           |                                                    |
|                                | Sta<br>Registi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | 31. Date filed (Month, Day, Year)<br>FEB 1 4 2008                                                          | Scene &                                                                                |                                     |                                                                   |                                            |                                          |                                                 |                                                    |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **HENDERSON** DALE ANTHONY -Mbnth **Physician** tehruar 2008 /Medical 4c. County of Death
Prince Georges 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lanham Doctor's Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 579-90-9747 1 XM 2 ☐ F 46 Yrs. Cleveland, CH Director Usual Residence of Decedent death with the Maryland 3a or 28a-f show t be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Fort Washington MD Prince Georges 1X Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 5502 Haras Place 20744 "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specif Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Private Agent Leasing the marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith Bennett 1 and 2 should be 1 Health and Mental Elliott Henderson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If Item 27 is m any Injury or other traum Pages 1 and 2 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of the and 10 of 5400 Lane Temple Hills, MD Edith Henderson Mother Joel Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD National Memorial Park 02/18/2008 Laurel, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bianchi 814 Upshur St NW Wash, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of): Examiner ellmon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tran Due to (or as a consequence of) physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an cate has t autopsy certificate 2 No 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. 2 Accident the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated.

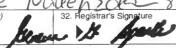
law requires that the death certificate be executed Box 68760. P.O. Records, Division or Vital

Jale  $\mathcal{H}epderSOA$ Baltimore, Maryland 21215-0036

2

State Registrar 31. Date filed (Month, Day, Year) 2008 FEB 14

29b. Signature and title of certifier



30r Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

18 Good Luck Road, Lanham, MD, 20706

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | _1               | For<br>State<br>Registrar                                                                                                                  |                                               | State o                                       | f Mary                  |                               |                       | ment of H<br><i>licate of L</i>                                      | ealth and N<br>Death                                 |                                        | giene<br>Reg. No                 | 2000                             | 06345                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------|-------------------------|-------------------------------|-----------------------|----------------------------------------------------------------------|------------------------------------------------------|----------------------------------------|----------------------------------|----------------------------------|----------------------------------------------------|
| Physicia:<br>/Medica                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | n                | 1. Decedent's Name<br>Matth                                                                                                                | e (First, Middle,<br>new Impe                 | ,                                             |                         |                               |                       |                                                                      |                                                      | 2. Date of De<br>Month                 | Da                               | y Year                           |                                                    |
| Examine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | r                | 4a. Facility Name (II<br>44 Chesa                                                                                                          | peake L                                       | anding                                        |                         |                               | A                     | nnapolis                                                             |                                                      |                                        | 4c. County of Death Anne Arundel |                                  |                                                    |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 5. Social Security N  216-04-8  Usual Residence of                                                                                         | 553                                           | 6. Sex<br>XX M 2□ F                           | 30                      | yrs. last birth               |                       | Under 1 Year<br>onths Days                                           | If Under 24 Hrs.<br>Hours Min.                       | 8. Date of Bir<br>(Month, Da<br>Aug. 1 | ay, Year)                        | 1                                | irthplace (State or Foreign<br>Country)<br>iryland |
| Maryland -f show fied at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | .                | <sup>10a. State</sup><br>Maryland                                                                                                          | 10b. County                                   | Arundel                                       |                         | c. City, Town                 |                       | on                                                                   |                                                      |                                        |                                  |                                  | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No             |
| h with the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | runeral Director | 10e. Street and Nur<br>44 Chesa                                                                                                            | mber                                          |                                               |                         | широ                          |                       | 10f. Zip Code<br>21403                                               |                                                      |                                        |                                  | izen of What C                   | Country?                                           |
| al", o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <u>~</u>         | 11. Marital Status<br>1                                                                                                                    | ied 🏋 🏋 Marri                                 | 12. Was Dece<br>Armed Fo                      | rces?<br>XXXNo<br>/e    | in U.S.                       |                       | Decedent of Hies, specify Cuba                                       | spanic Origin? (Sp<br>n, Mexican, Puerlo<br>Specify: | pecify Yes or No<br>Rican, etc.)       |                                  | 14. Race - An<br>Black, Wh       | nerican Indian,                                    |
| within 72 ho<br>iene.<br>• than "natui<br>the Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Сотрыетеа        | (Spec                                                                                                                                      |                                               | s Education<br>t grade completed) College (** | -4or 5+)                |                               | Give kind<br>life. DÖ | 's Usual Occupa<br>d of work done of<br>NOT use retired,<br>ter Tecl | luring most of worl<br>)                             | king                                   |                                  | ind of Busines                   | •                                                  |
| Mental Hyg<br>Mental Hyg<br>arked other<br>atic event, i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | 17. Father's Name (                                                                                                                        |                                               | •                                             |                         |                               | 18. Mother's Nam      | •                                                                    | e, Maiden                                            |                                        |                                  |                                  |                                                    |
| and 2 sho<br>fealth and<br>m 27 is m<br>her traum:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                            | L. Impe                                       | ip (Type. Print)<br>tt / Fath                 |                         | 44                            | Che                   | sapeake                                                              |                                                      | Annapo                                 | olis                             | , Maryl                          | and 21403                                          |
| iit. Pages 1 artment of H artant: If ite njury or ot                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 20a. Method of Disp<br>1 ☐ Burial <b>X</b><br>4 ☐ Donation<br>21. Signature of Fu                                                          | Cremation<br>5 □ Other (Sp                    |                                               | State                   |                               | , cremati<br>ore (    | ory or other place<br>Cremator                                       | e)<br>cy 2/11/                                       |                                        | Bali                             | cation - City o                  | Maryland                                           |
| Deps<br>Impo<br>any I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | -                | 23a. Part1. Enter the                                                                                                                      | he disease, or                                | complications that of                         | aused the               | death. Do no                  | 147                   | Duke of                                                              | f Glouces                                            | ster St.                               | . Anr                            |                                  | ral Home, Inc.<br>, MD 21401                       |
| Physician<br>/Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ĺ                | shock, or hea<br>Immediate Cause (<br>disease or condition<br>resulting in death)                                                          | ırt failure. List o<br>(Final                 | only one cause on e                           | ach line.<br>Acut       |                               | elo                   | id le                                                                |                                                      | or respiratory c                       | 211631,                          |                                  | Interval Between<br>Onset and Death                |
| ficate be executed with physician and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street burial-transit and street | euicai Examiner  | Sequentially list coi<br>if any, leading to im<br>cause. Enter Unde<br>Cause (Disease or<br>that initiated events<br>resulting in death) L | erlying<br>injury<br>S                        | b                                             | or as a co              | nsequence of                  | j):                   |                                                                      |                                                      |                                        |                                  |                                  |                                                    |
| ath certi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown                                                                        | months?<br>☐ No                               |                                               | irth 2 🗀<br>ant at time | Fetal death                   |                       | topic pregnancy<br>her (specify)                                     |                                                      |                                        |                                  | 23d. Date of d<br>Month          | lelivery<br>Day Year                               |
| w requires that the de been signed by the should be detached is                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ò                | Part II. Other signif                                                                                                                      | ficant conditio                               | ns contributing to d                          | eath but no             | ot resulting in t             | the unde              | rlying cause give                                                    | en in Part I.                                        | 23e. Did                               |                                  | 1                                | to the cause of death?<br>Probably 4 □Unknown      |
| i: The law ricate has be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Completed        |                                                                                                                                            |                                               |                                               |                         |                               |                       |                                                                      |                                                      | 24a. Was<br>auto<br>perf<br>1□ Yes     |                                  | prior to<br>death                |                                                    |
| ding Physlcian: The h. After this certificate funeral director, pag                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2                | 25. Was case referrexaminer? 1 ☐ Yes 2  27. Manner of Deatl                                                                                | No                                            | Hospital: 1  28a. Date                        | npatient                | 2 ER/Outp                     |                       | 3 DOA Othe                                                           | 4 □ Nursing H                                        |                                        | idence                           | 6 □Other (S <sub>k</sub>         | pecify)                                            |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, it                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | IIICarion        | 1 Natural 2 Accident 3 Suicide 4 Homicide                                                                                                  | 5 Pending investigation 6 Could not determine | ation (Mon                                    | th, Day Ye              | At home, farn                 | jury                  | 28c. Injury Work  M 1 1                                              | Yes 2□No                                             |                                        | (Street a                        | nd Number or                     | Rural Route Number,                                |
| To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Medical cel      | 29a. Certifier<br>(Check only<br>one)                                                                                                      | 1 Certifying                                  | Physician: To the Examiner: On the b          | asis of exa             | y knowledge,<br>amination and | death od              | curred at the tim                                                    | ne, date and place<br>pinion, death occu             | , and due to the                       | e cause(s                        | s) and manner<br>od place, and d | as stated.<br>lue to the cause(s)                  |
| To the within To the comple                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Me               | 29b. Signature and                                                                                                                         | title of certifier                            | And man                                       | ner stated.             |                               |                       | 29c. License                                                         | number 52391                                         |                                        | - 1                              |                                  | onth, Day, Year)                                   |
| CH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 30. Name and addr                                                                                                                          | Levis                                         | 1650                                          | Orle                    | (Item 23a) (T                 | ype, Prir             | - Roanz                                                              | 43 Balt                                              | more y                                 | laryla                           | and 2                            | 123)                                               |
| State<br>Registra                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | r                | 31. Date filed (Moni                                                                                                                       | EB 1 2                                        | 2008                                          | egistrar's              | Signature                     | dose                  | E .                                                                  | 43 Balt                                              |                                        |                                  |                                  |                                                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Catherine Rachel Jones February 12. 2008 1250 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 □ M 2 X F Maryland Director 67 217-44-8911 May 24, 1940 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10h. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Calvert Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20657 Funeral 8371 Circle Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1√ Never Married 2 Married 1 ☐Yes 21 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No γ Specify Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. Someone Else's Home Domestic is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Arthur S. Jones Mary Ellen Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health an Item 27 8371 Circle Drive, Lusby, MD 20657 Magella Kincaid - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Itel any injury or ott 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Ernestine Jones Cemetery 2/16/2008 Chesapeake Beach, MD 21. Signature of Funeral Service Licenses Glady Sewell Funeral Home, PA, 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MD AIXOUPH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner be executed PARTA Due to (or as a consequence of): the attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No AIGUMONIA 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1□ Yes 2₽No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined

Box 68760. P.O. Records, Division or Vital

al or Attending Patter death. 24 hours a Hospital

State Registrar

within 24

á

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAWE Ams32AW.

D0064961

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

NIL

and manner stated.

110 HUSDIRA

31. Date filed (Month, Day, Year) 32. Registrar Signature 2008 13

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

|                            |                                                                                                                                                                                                                                                                                                  |                       | For<br>State<br>Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | State of Ma                                                      | aryland        | -                   | artment o                        |                      |                                    |                              | giene<br>Reg. No. 4 | 2008                            | 06347                                          |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------|---------------------|----------------------------------|----------------------|------------------------------------|------------------------------|---------------------|---------------------------------|------------------------------------------------|
|                            | Physici                                                                                                                                                                                                                                                                                          | an                    | 1. Decedent's Name (First, Middle, Las                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | •                                                                |                |                     |                                  |                      |                                    | 2. Date of Dea<br>Month      |                     | Year                            | 3. Time of Death                               |
|                            | /Medic                                                                                                                                                                                                                                                                                           |                       | Ruth Ann Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  |                |                     |                                  |                      |                                    | Month<br>Tebruar             |                     |                                 | 12:15 PM                                       |
|                            | Examin                                                                                                                                                                                                                                                                                           | er                    | 4a. Facility Name (If not institution, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                  | _              |                     | 4b. City, Tov                    |                      |                                    |                              |                     | County of Death                 |                                                |
|                            | F                                                                                                                                                                                                                                                                                                |                       | 2520 Kensington Ga 5. Social Security Number 6. Se                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                  |                | st birthday)        | Ellico                           |                      |                                    | 3. Date of Birt              | h                   | ward<br>9. Birthi               | place (State or Foreign<br>ntry)               |
| Ċ                          | Funeral<br>Director                                                                                                                                                                                                                                                                              |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | _M 2 <b>/</b> 2 F                                                | 66             | Vrs                 | Months D                         | ays Hou              |                                    | (Month, Day                  |                     |                                 | esota                                          |
|                            | yland<br>how<br>at                                                                                                                                                                                                                                                                               |                       | 10a. State 10b. County                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                  | 10c. City,     | Town or Lo          | cation                           |                      |                                    |                              |                     |                                 | 10d. Inside City Limits                        |
|                            | e Mar<br>ta-f sl                                                                                                                                                                                                                                                                                 | cto                   | MD Howard                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  | E11i           | cott                | City                             |                      |                                    |                              |                     |                                 | 1 ☐ Yes 2 No                                   |
|                            | or 28                                                                                                                                                                                                                                                                                            | Funeral Director      | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                  |                |                     | 10f. Zip Co                      |                      |                                    |                              |                     | en of What Cou                  | ntry?                                          |
|                            | s 23a                                                                                                                                                                                                                                                                                            | ra                    | 2520 Kensington Ga                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                  |                | 140                 | 21043                            |                      | Origin? (Spec                      |                              | JSA                 | 4. Race - Americ                | can Indian                                     |
|                            | item<br>item                                                                                                                                                                                                                                                                                     | Ľ,                    | 11. Marital Status 1 ☐ Never Married 2 ☐ Married                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 12. Was Decedent I<br>Armed Forces?<br>1 Yes 2 X                 | lo<br>No       | , 13.               | If Yes, specify                  | Cuban, Me            | c Origin? (Spec<br>xican, Puerto R | ican, etc.)                  |                     | Black, White,                   |                                                |
| 936                        | urs af                                                                                                                                                                                                                                                                                           | ρ                     | 3 Widowed 4 Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | If Yes, Give<br>Year or Dates:                                   |                |                     | 1 ☐ Yes 2 ☐                      | (No <i>Sp</i> e      | ecify:                             |                              |                     | <sup>Specify:</sup> Whi         | te                                             |
| 21215-0036                 | 72 hours after death with the Maryland<br>'natural', or items 23a or 28a-f show<br>'frai Examiner must be notified at                                                                                                                                                                            | Completed             | 15. Decedent's Ed<br>(Specify only highest gra                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ucation<br>de completed)                                         |                | 16a. Dece           | dent's Usual C                   | occupation           | most of working                    | a l                          | 16b. Kin            | d of Business/In                | ndustry                                        |
| 21                         | within iene. than "u                                                                                                                                                                                                                                                                             | nple                  | Elementary/Secondary (0-12)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | College (1-4or 5                                                 |                |                     |                                  |                      | most of working                    |                              | -                   |                                 |                                                |
|                            | filed withi<br>Hygiene.<br>other than<br>ent, the M                                                                                                                                                                                                                                              |                       | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4                                                                |                | Claim               | s Repre                          |                      | tive<br>Nother's Name              | (First Middle                |                     | rance                           |                                                |
| and                        | ould be fi<br>Mental F<br>iarked ott                                                                                                                                                                                                                                                             | Be                    | Albert H. Haakenso                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | vn                                                               |                |                     |                                  |                      | h Pearl                            |                              |                     | ourname)                        |                                                |
| Maryland                   | should<br>ind Men<br>marke                                                                                                                                                                                                                                                                       | ပ                     | 19a. Informant's Name/Relationship                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                  |                | 19b. Maili          | na Address (S                    |                      |                                    |                              |                     | Town, State, Zij                | p Code)                                        |
| Ma                         | nd 2 shoulth and 27 is ma                                                                                                                                                                                                                                                                        | H                     | Sam Johnson/son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,                          |                | l                   | _                                |                      | Hanover                            |                              |                     |                                 | ,                                              |
|                            | s 1 and 2<br>f Health<br>Item 27 I                                                                                                                                                                                                                                                               | h 8                   | 20a. Method of Disposition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                  | 20b. Pla       | ace of Dispo        | osition (Name of matory or other | of<br>erplace)       | Da                                 | ate                          | 20c. Loc            | cation - City or T              | own, State                                     |
| Ë                          | Pages<br>nent of I<br>ant: if Ite                                                                                                                                                                                                                                                                |                       | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification Specification Specifi |                                                                  |                |                     |                                  |                      | 02/14                              | /08                          | Belt                | sville,                         | MD                                             |
| Baltimore,                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Merical Examiner must be notified at once. |                       | 21. Signature of Funeral Service Licer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1)-11                                                            | MO125          | G                   | 2. Name and A                    | Address of F         | acility<br>emation                 | n Serv                       | ice                 | P.O. Bo                         | x 784<br>e, MD 21029                           |
|                            | Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                | Examiner              | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to Immediate Cause. Enter Underlying Cause, Disease or injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | a. Due to (or as                                                 | a consequ      | ence of):           | 5.00                             | guy                  |                                    | respiratory a                | rrest,              |                                 | Approximate Interval Between onset and Death   |
| Box 68760,                 | death certificate be executed<br>e attending physician and<br>of for use as the burial-transit                                                                                                                                                                                                   | Physician/Medical Exa | that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Due to (or as d                                                  | pf pregnar     | ncy<br>death 3[     | □Ectopic preg<br>□ Other (spec   |                      |                                    |                              | 2                   | 23d. Date of deliv              | <i>v</i> ery<br>Day Year                       |
| O.                         | the de                                                                                                                                                                                                                                                                                           | ysic                  | 1 ☐ Yes 2 █ No<br>9 ☐ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 9□Unknown                                                        | t time of de   | atti J              | Other (speci                     | ny)                  |                                    |                              |                     |                                 |                                                |
| 0                          | w requires that the d<br>been signed by the<br>should be detached                                                                                                                                                                                                                                | by                    | Part II. Other significant conditions of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ontributing to death b                                           | ut not resu    | Iting in the u      | ınderlying caus                  | se given in F        | Part I.                            | 23e. Did 1                   | 3                   |                                 | the cause of death?                            |
| Recol                      | has<br>has                                                                                                                                                                                                                                                                                       | Completed             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                  |                |                     |                                  |                      |                                    | 24a. Was<br>auto<br>perfo    |                     | 24b. Were aut prior to codeath? | topsy findings available ompletion of cause of |
| ital                       | sician: Th<br>certificate<br>rector, pag                                                                                                                                                                                                                                                         | BeC                   | 25. Was case referred to medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  |                |                     |                                  | 26.                  | Place of Death                     |                              | 4                   |                                 |                                                |
| >                          | Physici<br>this ce<br>al direc                                                                                                                                                                                                                                                                   | To B                  | examiner?<br>1 ☐ Yes 2 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Hospital: 1 ☐ Inpatio                                            | ent 2 🗆 🛭      | ER/Outpatie         | nt 3□ DOA                        | Other: 4             | ☐ Nursing Hor                      | ne 5 Mi Resi                 | dence (             | 6 □Other (Spec                  | sify)                                          |
| n o                        | ding Ph<br>n.<br>After th<br>funeral                                                                                                                                                                                                                                                             |                       | 27. Manner of Death  1 Watural 5 Pending                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 28a. Date of Inju<br>(Month, Da                                  | ıry<br>y Year) | 28b. Time of Injury | of 28c                           | . Injury at<br>Work? |                                    | 8d. Describe                 | how injur           | y occurred                      |                                                |
| Division or Vital Records, | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,                                                                                                                               | Certification:        | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                  |                |                     | M treet, factory, o              | 1 ☐ Yes              |                                    | 8f. Location (<br>City or To |                     |                                 | ral Route Number,                              |
|                            | le Hospit<br>124 hour:<br>le Funers<br>letely fille                                                                                                                                                                                                                                              | edical C              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | nysician: To the best<br>miner: On the basis of<br>and manner st | of examinat    |                     |                                  |                      |                                    |                              |                     |                                 |                                                |
|                            | To th<br>withir<br>To th<br>comp                                                                                                                                                                                                                                                                 | Me                    | 29b. Signafule and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                  | /              |                     | 29c. L                           | icense num           | nber                               |                              | 29d. Dat            | te signed (Month                | n, Day, Year)                                  |
|                            |                                                                                                                                                                                                                                                                                                  |                       | > \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Ludiel                                                           | X              |                     | 7                                | 385                  | 200/                               |                              | Tebr                | wary 13                         | ,2003                                          |
| 10                         | ) a                                                                                                                                                                                                                                                                                              |                       | 30. Name and address of person who                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | completed cause of o                                             | death (Item    | 23a) (Type          | , Print)                         | DI                   | P1 1                               |                              |                     | 15111/                          |                                                |
| J.                         | 100                                                                                                                                                                                                                                                                                              |                       | 10 1000 May 1200 xc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Jubro 110                                                        | rar's Signat   | 4416 / A            | XUXUU                            | + KK                 | Wille                              | ping M                       | D3                  | -1044                           |                                                |
|                            | St<br>Regist                                                                                                                                                                                                                                                                                     | ate<br>rar            | 31. Date filed (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 22. Hagist                                                       | ai a oiyila    | le le               | 1.0.                             |                      |                                    |                              |                     |                                 |                                                |

Registrar
DHMH 17 Rev 1/2001

State

1500 FOREST GLEN ROAD, SILVER SPRING, MARYLAND

30. Name and address of person who comp d cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DR. KANWALJIT NAGI

FEB 13

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                     |                                                                                                                                                                                   |                  | For State Of Wai yiand / De State Registrar                                                                                                                                                                                   | Certificate of De                                                                 |                                       |                                                | . No. 2008                                   | 06349                                              |  |  |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------|------------------------------------------------|----------------------------------------------|----------------------------------------------------|--|--|
| ļ                   | Physici                                                                                                                                                                           | an               | Decedent's Name (First, Middle, Last)     Annie Virginia Johnson                                                                                                                                                              |                                                                                   | 2                                     | Date of Death<br>Month<br>02/ 02/              | Day Year                                     | 3. Time of Death                                   |  |  |
|                     | /Medic                                                                                                                                                                            | no other         | Annie Virginia Johnson  4a. Facility Name (If not institution, give street and number)                                                                                                                                        | ocation of Death                                                                  | 02/ 02/                               | 4c. County of Deat                             | 0950 A M                                     |                                                    |  |  |
|                     | LAdiiiii                                                                                                                                                                          | CI               | Cherry Lane Nursing Center                                                                                                                                                                                                    |                                                                                   |                                       | PG                                             |                                              |                                                    |  |  |
| 54                  | Funeral<br>Director                                                                                                                                                               |                  | 5. Social Security Number 229-44-9271  6. Sex 1 □ M 2 ▼ 72  Yn                                                                                                                                                                | f Under 24 Hrs. 8<br>Hours Min. (                                                 | Date of Birth (Month, Day, ) 05/16/19 | 9. Birt<br><i>Co</i><br><b>Vi</b>              | nplace (State or Foreign<br>untry)<br>rginia |                                                    |  |  |
|                     | yland<br>tow                                                                                                                                                                      |                  | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town of the county                                                                                                                    |                                                                                   |                                       |                                                | 10d. Inside City Limits                      |                                                    |  |  |
|                     | a-f sh<br>tiffed                                                                                                                                                                  | ctor             | MD PG Blad                                                                                                                                                                                                                    |                                                                                   |                                       | 1 XYes 2 No                                    |                                              |                                                    |  |  |
|                     | with th                                                                                                                                                                           | Funeral Director | 10e. Street and Number 4112 - 56th Avenue                                                                                                                                                                                     | 10g                                                                               | 10g. Citizen of What Country          |                                                |                                              |                                                    |  |  |
|                     | ns 23                                                                                                                                                                             | eral             |                                                                                                                                                                                                                               | fy Yes or No-                                                                     | U.S.A.                                | rican Indian,                                  |                                              |                                                    |  |  |
| Maryland 21215-0036 | be filed within 72 hours after death with the Maryland<br>Ital Hygiene.<br>Id other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at |                  | Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☐ Yes, Give Year or Dates:                                                                                                                                            | eanic Origin? (Spect<br>Mexican, Puerto Ri<br>Specify:                            | ćan, etc.)                            | Black, White                                   | _                                            |                                                    |  |  |
| 2-0                 | "natur                                                                                                                                                                            | leted            | 15. Decedent's Education 16a. D (Specify only highest grade completed) (6                                                                                                                                                     | ecedent's Usual Occupation Give kind of work done during ife. DO NOT use retired) | on<br>ring most of working            | 16                                             | b. Kind of Business/                         | ndustry                                            |  |  |
| 121                 | within<br>iene.<br>than<br>the Me                                                                                                                                                 | Completed by     | Elementary/Secondary (0-12)   College (1-4or 5+)                                                                                                                                                                              | Nurse Assist                                                                      |                                       |                                                | Private                                      |                                                    |  |  |
| שם                  | al Hygie<br>I other<br>vent, th                                                                                                                                                   | Be C             | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                       | 18                                                                                | 8. Mother's Name (i                   |                                                | -                                            |                                                    |  |  |
| Sla                 | should be<br>and Mental<br>marked c                                                                                                                                               | 2                | Lewis Talley                                                                                                                                                                                                                  |                                                                                   |                                       | O. Wynn                                        |                                              |                                                    |  |  |
| Mar                 | S 6 8 18                                                                                                                                                                          |                  |                                                                                                                                                                                                                               | Aailing Address (Street and 12 – 56th Av                                          |                                       |                                                |                                              | -                                                  |  |  |
|                     | es 1 and<br>of Health<br>f Item 27<br>r other tr                                                                                                                                  |                  | 20a. Method of Disposition 20b. Place of D                                                                                                                                                                                    | Disposition (Name of crematory or other place)                                    |                                       |                                                | c. Location - City or                        |                                                    |  |  |
| <u>E</u>            | Pages<br>ment of<br>ant: If It<br>ury or o                                                                                                                                        |                  |                                                                                                                                                                                                                               | incoln Cemet                                                                      | ery 02/08                             |                                                |                                              | Maryland                                           |  |  |
| Baltimore,          | permit. Pages<br>Department of<br>Important: If II<br>any Injury or once.                                                                                                         |                  | 21. Signature of Funeral, Service Licensee  22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748                                                                           |                                                                                   |                                       |                                                |                                              |                                                    |  |  |
|                     |                                                                                                                                                                                   |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.                                                                                      | t enter the mode of dying,                                                        | such as cardiac or i                  | respiratory arres                              | ,                                            | Approximate<br>Interval Between<br>Onset and Death |  |  |
|                     | Physician /<br>/Medical                                                                                                                                                           |                  | Immediate Chise (Final disease or condition resulting in death)  Respiratory Failure a.                                                                                                                                       |                                                                                   |                                       |                                                |                                              | Oriset and Death                                   |  |  |
|                     | Examiner                                                                                                                                                                          |                  | Due to (or as a consequence of)  Chronic Obstructi                                                                                                                                                                            |                                                                                   | isease                                |                                                |                                              |                                                    |  |  |
|                     | ± q                                                                                                                                                                               | ner              | Sequentially list conditions, literal Letter Land the Letter Land Letter Land Letter Land Letter Land Letter Land Letter Land Letter Land Letter Land Letter Land Letter Land Letter Land Letter Land Letter Land Letter Land |                                                                                   |                                       |                                                |                                              |                                                    |  |  |
|                     | icate be executed<br>physician and<br>s the burial-transit                                                                                                                        | Examiner         | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of)                                                                                           |                                                                                   |                                       |                                                |                                              |                                                    |  |  |
| 68760,              | s be ey                                                                                                                                                                           |                  | Sate to for all a consequence on                                                                                                                                                                                              | •                                                                                 |                                       |                                                |                                              |                                                    |  |  |
| 9                   | ± 0 €                                                                                                                                                                             | Medical          | d                                                                                                                                                                                                                             |                                                                                   |                                       |                                                |                                              |                                                    |  |  |
| .O. Box             | death ce<br>e attendii<br>d for use                                                                                                                                               | Physician/N      | IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1                                                                                                                                                                |                                                                                   |                                       |                                                |                                              |                                                    |  |  |
| <u> </u>            | s that i                                                                                                                                                                          | by Ph            | Part II. Other significant conditions contributing to death but not resulting in the                                                                                                                                          | he underlying cause given                                                         | in Part I.                            | 23e. Did toba                                  | cco use contribute to                        | the cause of death?                                |  |  |
| ğ                   | w requires<br>been signe<br>should be                                                                                                                                             | ed b             | Hypertension                                                                                                                                                                                                                  |                                                                                   |                                       | 1 ☐ Yes                                        | 2 <b>⊠</b> No 3□Pr                           | obably 4 Unknown                                   |  |  |
| I Records,          | The la<br>ate has<br>page 2                                                                                                                                                       | Completed        |                                                                                                                                                                                                                               |                                                                                   |                                       | 24a. Was an<br>autopsy<br>performe<br>1□ Yes 2 | prior to o                                   | topsy findings available completion of cause of    |  |  |
| Vital               | Physiclan: The land this certificate had alrector, page 2                                                                                                                         | Be               | 25. Was case referred to medical examiner?  Hospital: Hospital:                                                                                                                                                               |                                                                                   | 6. Place of Death (                   |                                                |                                              |                                                    |  |  |
| ō                   | Phy<br>this                                                                                                                                                                       | 은                | 1  Yes 2  No                                                                                                                                                                                                                  | atient 3 DOA Other: ne of 28c. Injury at Work?                                    |                                       | e 5 Residence                                  | ce 6 Other (Spe                              | cify)                                              |  |  |
| ion                 | tending Reath. tor: After the funer                                                                                                                                               | ation            | 1 ☑Natural 5 □ Pending (Month, Day Year) Inju<br>2 □ Accident investigation                                                                                                                                                   |                                                                                   | s 2 No                                |                                                | ,.,                                          |                                                    |  |  |
| Division            | 200>                                                                                                                                                                              | Certification:   | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)                                                                                                                         | n, street, factory, office                                                        | 28                                    | f. Location (Stre<br>City or Town,             | et and Number or Ru<br>State)                | ıral Route Number,                                 |  |  |
| _                   | e Hospital or A<br>24 hours after<br>e Funeral Dire<br>etely filled in b                                                                                                          |                  | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, of                                                                                                                                                        | death occurred at the time                                                        | date and place, an                    | id due to the cau                              | se(s) and manner as                          | stated                                             |  |  |
|                     | To the Hosp<br>within 24 hosp<br>To the Fune<br>completely f                                                                                                                      | Medical          | (Check only one) 2 Medical Examiner: On the basis of examination and/one) and manner stated.                                                                                                                                  | or investigation, in my opin                                                      | nion, death occurred                  | d at the time, date                            | e and place, and due                         | to the cause(s)                                    |  |  |
|                     | vithii<br>To th                                                                                                                                                                   | Ž                | 29b. Signature and title of certifier                                                                                                                                                                                         | 29c. License n<br>D00452                                                          |                                       | I .                                            | Date signed (Mont                            | h, Day, Year)                                      |  |  |
| )                   | (2)                                                                                                                                                                               |                  | - Chinh we                                                                                                                                                                                                                    |                                                                                   | .1 /                                  | 0                                              | 2/08/2008                                    |                                                    |  |  |
| 2                   | (3)                                                                                                                                                                               |                  | 30. Name and address of perfor who completed cause of death (Item 23a) (Ty 6201 Greenbelt Road; college Park, Maryland                                                                                                        |                                                                                   | .3.1. 3                               | · .                                            |                                              | 3)                                                 |  |  |
| Ī                   | Sta<br>Registr                                                                                                                                                                    |                  | 31. Date filed (Month, Day Year) FEB 1 4 2008 32. Registrar's Signate                                                                                                                                                         | 20/40 Dr. A                                                                       | debowale Aj                           | ayi                                            |                                              |                                                    |  |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 10:26P <sup>™</sup> Julia Samanez de Klien 12, 2008 /Medical February, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) R7 Yrs. Months Days Hours Min. Feb 6, 1921 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Feb 6, Peru Director N/A Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1√TYes 2□No Director Lima 18 Peru 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Av. 15 DE Enero 118 (unk) Peru Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1X Yes 2 □ No Specify: Specify: White þ Peruvian 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within; th and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) 12 College (1-4or 5+) Real Estate Real Estate Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elias Samanez Consuelo Samanez-Ocampo ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. 3714 Williams Lane Chevy Chase, MD 20815 Monica Klien/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 02/14/08 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MO1251 Approximate Interval Between Onset and Death Immediate Cause (Final Physician aSevere Cerebral Vascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bAtrial Fibrillation Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence o Examiner been signed by the attending physician and should be detached for use as the burial-transi Coronary Artery Disease Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy performed 2 X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatyre and title of den fier 29c. License number 29d. Date signed (Month, Day, Year) Dulau Quv) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 8600 Old Georgetown Rd. Bethesda, MD 20814 Zenuz Sima Nourani, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 15 2008 Registrar

DHMH 17 Rev 1/2001

SAMAK

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician February 22, Dorothy Elizabeth Knott 4:36 A M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 2, 1927 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 □ M 2 1 F 216-80-3702 80 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits St. Mary's Maryland Clements 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20624 USA Funeral 24465 Budds Creek Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White þ Specify 3 XWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Own Home College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philip Columbus Quade Elizabeth Ann Pilkerton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Jean Knott / Grand-daughter 24465 Budds Creek Road Clements, MD 20624 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State February 26, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph's Cemetery Morganza, Maryland 4 Donation 5 Dother (Specify) 2008 21. Signature of Funeral Service Ligerisee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home. P.O. Box 270 Leonardtown, MD 20 ▶ fardine Leonardtown, MD 20650 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown icate has been s , page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 □ No Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. Lîcense number 290. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William D. Boyd, II, M.D. 25365 Pt. Lookout Road Leonardtown, MD 20650 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State 2008 FEB Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 06352 Kenneth William Luhn 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day February 24, 2008 0929 hrs Kenneth William Luhn Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown 9119 Crystal Falls Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. Country) MD Director 11-30-1932 217-28-6472 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Ę 10a, State 10b. County 1 Yes 2 X No ilmore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Ffeatht and Mental Prygener of the stand and Mental Prygener of the stand 71 is marked other than "natural", or items 23a or 28a-1 show or other tranumalt event, the Makifical Examiner must be notified at once. Hagerstown MD Washington Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number Crystal Falls Drive 21713 II.S A 9119 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 1 X Yes If Yes, Give Year Yes 2 No specify: Widowed 4 Divorced 53-55 White þ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 Masonry East Alco 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Bradley Luhn Sr. Helen Martha Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Falls Dr Hagerstown MD 21713 Crystal Pat B. Luhn 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 1-26-2008 Smithsburg, MD Smithsburg Crem Donation 5 Other Specify: 22. Name and Address of Facility Keeney & Basford P.A. 21. Signature of Funeral Service Ligensee M01176 106 East Church St Frederick 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and ailure. List only one cause on each line. /Medical Death Hypothermia complicating hypertensive atherosclerotic cardiovascular Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): disease Sequentially list conditions. if any, leading to immediate Due to for as a consequence of a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 27,28a-f. perME,g877, 3/4/08 TT icate has been signed by the attending physician page 2 should be detached for use as the burial Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. è Yes 2 No 3 Probably 4 V Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 No 1 Yes certificate the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical funeral director, Division of Vital Be examiner? Other<sub>4</sub> Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Certification: exposed to low environmental Natural Yes 2 X No Director: Pending FNd 2/24/2008 hours after death. Fnd 9:20 am temperature 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be 9119 Crystal Falls Dr. Hagerstown, MD Suicide (Specify) woods Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the state and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 25, 2008 O.C.M.E. MA 01 aishe 30. Name and address of person who completed/cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

**OCME** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 23, 2008 **Physician** 10:08 PM Ruth G. Lyon February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mount Airy Frederick Kline Hospice House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 25, 1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Pennsylvania 1 M 2 X F 276-22-6985 82 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show a or 28a-f show the notified at 10c. City. Town or Location 10d, Inside City Limits 10a. State 10b. County Frederick New Market 1 ☐ Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21774 6632 Commodore Court United States "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify White ð 3 Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert B. Gerdtz Edith Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Howard / Daughter 6632 Commodore Court, New Market, Maryland 21774 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department c Important: If any injury or once. Smithsburg, Maryland 25, 2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lie Name and Address of Facility Leeney & Basford P.A. Funeral Home O6 East Church Street, Frederick, MO1433 MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** espiratoru /Medical Due to (or as a onsequence of): Examiner cancer S. pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ina Due to (of as a consequence of) requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3☐Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown by signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 🗌 Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho 24a. Was an autopsy performed? Yes 2 2 No certificate has Yes Physiclan: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Wother (Specify) 1 ☐ Yes 2010 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Hospiee 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the ' 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

P.0. Division or Vital Records, To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

> State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Pay, Year) 32. Registrar's Signature

MID

D0056786

29c. License number

29d. Date signed (Month, Day, Year) Feb 25, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Nahila Shad 9093 Ridge field Dr, Suite 104, Frederick

**ORIGINAL** 

|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | •                | For State Registrar                                                                                                                                                                                                                      | Cei                             | rtificate of l                                                   |                                                     | Re                                          | g. No.                           | JO                       | UO                                     | ) J 4              |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------|----------------------------------|--------------------------|----------------------------------------|--------------------|
|             | Physicia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | an               | Decedent's Name (First, Middle, Last)     Agnes McCarrick Long                                                                                                                                                                           |                                 |                                                                  |                                                     | 2. Date of Death<br>Month                   | Day Y                            | ear                      | 3. Time of                             | Death<br>A M       |
|             | /Medic<br>Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | al .             | 4a. Facility Name (If not institution, give street and number)                                                                                                                                                                           |                                 |                                                                  | r Location of Death                                 | February                                    | 4c. County of                    | Death                    | 5:14                                   |                    |
|             | nt vi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | To the second    | Anne Arundel Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs                                                                                                                                                             | s. last birthday)               | Anna<br>If Under 1 Year                                          | apolis                                              | 8. Date of Birth                            | Anne                             |                          | ndel                                   | r Foreign          |
|             | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 159-09-2148 1□ M 2XF 89                                                                                                                                                                                                                  |                                 | Months Days                                                      | Hours Min.                                          | Nov. 13                                     | <sup>Year</sup> 1918             | Count                    | nsylva                                 |                    |
| 1           | yland<br>how<br>at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                                                                                                          | ity, Town or Lo                 | ocation Ann                                                      | apolis                                              | ·                                           |                                  | 10                       | d. Inside Cit                          | -                  |
| į           | 28a-fs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Director         | 10e. Street and Number                                                                                                                                                                                                                   |                                 | 10f. Zip Code                                                    |                                                     | 10                                          | g. Citizen of Wh                 | at Count                 | 1 ☐ Yes                                | 2 <b>½</b> 1NO     |
|             | 23a or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 881 Clubhouse Village View                                                                                                                                                                                                               |                                 |                                                                  | 21401                                               |                                             | U.S.A                            |                          | .,.                                    |                    |
| 2-0036      | o within 7.2 mous arier beam with the maryand<br>jiene.<br>r than "natural", or Items 23a or 28a-f show<br>the Medical Examiner must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | by Funeral       | 11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes, Give  Yar or Dates:                                                                                                                           |                                 | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 ☒ No      | lispanic Origin? (Span, Mexican, Puerto<br>Specify: | pecify Yes or No-<br>Rican, etc.)           | 14. Race -<br>Black,<br>Specify: | White, e                 |                                        |                    |
| o i         | dia 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | leted            | 15. Decedent's Education<br>(Specify only highest grade completed)                                                                                                                                                                       | 16a. Dece                       | edent's Usual Occup<br>e kind of work done<br>DO NOT use retired | eation<br>during most of work                       | king 1                                      | 6b. Kind of Busi                 | iness/Ind                | ustry                                  |                    |
| 212         | filed within<br>Hygiene.<br>Ither than "<br>ent, the Med                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Completed        | Elementary/Secondary (0-12) College (1-4or 5+)                                                                                                                                                                                           | 1                               | tometer O                                                        |                                                     |                                             | Re                               | etai:                    | 1                                      |                    |
| <u> </u>    | e de la la la la la la la la la la la la la                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | To Be C          | 17. Father's Name (First, Middle, Last)  J. McCarrick                                                                                                                                                                                    |                                 |                                                                  |                                                     | ne (First, Middle, M<br>Bandholze:          | ,                                | )                        |                                        |                    |
|             | id z should<br>Ith and Men<br>27 Is marke<br>traumatic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 19a. Informant's Name/Relationship (Type. Print)  James A. Long, III/son                                                                                                                                                                 | 1                               | ing Address <i>(Street</i><br>Coachway                           |                                                     | ral Route Number,<br>Ls, Maryl              |                                  | tate, Zip<br>401         | Code)                                  |                    |
| e,          | permit. Pages 1 and<br>Department of Health<br>Important: If Item 27<br>any Injury or other ti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State                                                                                                                                                               | Place of Dispo<br>cemetery, cre | osition (Name of<br>ematory or other place                       |                                                     | -                                           | 20c. Location - C                | •                        |                                        |                    |
| altimore,   | t. Pag<br>tment<br>tant: h<br>ijury o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | 4 □ Donation 5 □ Other (Specify)                                                                                                                                                                                                         |                                 | ematory<br>22. Name and Addre                                    |                                                     |                                             | Baltimo:                         | _                        |                                        |                    |
| Ra          | Departing Department on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the concession on the co |                  | 21. Signature of Funjeral Service Licensee                                                                                                                                                                                               |                                 | 47 Duke o                                                        |                                                     |                                             |                                  |                          |                                        |                    |
| 1           | Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | Diala                                                                                                                                                                                                                                    | ath. Do not en                  | -2 1                                                             | ng, such as cardiac                                 |                                             | est,                             |                          | Approximate Interval Bette Onset and I | e<br>ween<br>Death |
| 68760,      | icate be executed physician and sthe burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Medical Examiner | Sequentially list conditions, if any leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consecutive that initiated events resulting in death) Last | equence of):                    | Stroke                                                           | )                                                   |                                             |                                  |                          | day                                    | y V                |
| .O. Box 6   | eath certif<br>attending<br>for use as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of                                                                      | etal death 3                    | □Ectopic pregnanc                                                | у                                                   |                                             | 23d. Date<br>Mon                 |                          |                                        | Year               |
| JS, P       | w requires that the deben signed by the sabould be detached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | by               | Part II. Other significant conditions contributing to death but not re                                                                                                                                                                   | esulting in the u               | underlying cause giv                                             | ven in Part I.                                      | 23e. Did tob                                | eacco use contril                | bute to th<br>3 ☐ Prob   |                                        | death?             |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Completed        |                                                                                                                                                                                                                                          |                                 |                                                                  |                                                     | 24a. Was ar<br>autops<br>perform<br>1 Yes 2 | 24b. W                           | ere autorior to coreath? | psy findings<br>npletion of c          | available          |
| Vital       | Physician:<br>r this certifica<br>ral director, I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Be               | 25. Was case referred to medical examiner?                                                                                                                                                                                               |                                 | ent 3 DOA Oth                                                    | oor:                                                | ath Check onl one                           |                                  |                          |                                        |                    |
|             | Phy<br>rthis<br>rald                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | T0               | 27. Manner of Death 28a. Date of Injury                                                                                                                                                                                                  | ER/Outpatie                     | SIR SU DOA                                                       | 4 🗀 Nursing r                                       | lome 5 Reside                               |                                  |                          | /)                                     |                    |
| Division or | or Attending I<br>after death.<br>Director: After<br>in by the funer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Certification:   | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined (Month, Day Year)  28e. Place of injury - At building, etc. (Spe                                                                 | home, farm, st                  | M 1□                                                             | rk?<br>]Yes 2□No                                    | 28f. Location (Str.                         | reet and Numbe<br>a. State)      | r or Rura                | l Route Nun                            | nber,              |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 29a. Certifier (Check only   Medical Examiner: On the basis of exami                                                                                                                                                                     | nowledge, dea                   | ath occurred at the tinvestigation, in my                        | ime, date and place                                 | e, and due to the ca                        | ause(s) and mar                  | nner as s                | lated.                                 | s)                 |
|             | To the Hospita within 24 hours To the Funeral completely filled                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Medical          | 29b. Signature and title of certifier                                                                                                                                                                                                    |                                 | 29c. Licens                                                      | se number                                           | 29                                          | 9d. Date signed                  | (Month,                  | Day, Year)                             |                    |
| ,           | 13                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 30. Name and address if person who completed cause of death (It                                                                                                                                                                          | em 23a) (Type<br><b>dical F</b> |                                                                  |                                                     | , Marvlar                                   | nd 2140                          | )1                       |                                        |                    |

State Registrar 31. Date filed (Month, Day, Year) FEB 1 2 2008

|                |                                                                                                                                                        |                   | State of Mary                                                                                                                                      |                        | artment of Hea                                    |                                        | ental Hyg                               |                         | 0 00000                                                                      |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|---------------------------------------------------|----------------------------------------|-----------------------------------------|-------------------------|------------------------------------------------------------------------------|
|                |                                                                                                                                                        |                   | 1 = State<br>Registrar                                                                                                                             | Cer                    | rtificate of De                                   |                                        |                                         | 3                       | 8 06355                                                                      |
|                | Physicia                                                                                                                                               | an                | 1. Decedent's Name (First, Middle, Last)                                                                                                           |                        |                                                   |                                        | <ol><li>Date of Dea<br/>Month</li></ol> | Day Y                   | 3. Time of Death                                                             |
|                | /Medic                                                                                                                                                 | al                | Joan Minalgo Lester                                                                                                                                |                        | 4b. City, Town, or Lo                             | action of Dooth                        | 2/13                                    | 3/2008<br>4c. County of | 8:20 a M                                                                     |
|                | Examin                                                                                                                                                 | er                | 4a. Facility Name (If not institution, give street and number)  10450 Lottsford Rd. #2012                                                          |                        | Mitchellv                                         |                                        |                                         | '                       | e George's                                                                   |
| ***            | Funeral                                                                                                                                                | 4,                | 5. Social Security Number 6. Sex 7. Age (III                                                                                                       | n yrs. last birthday)  | If Under 1 Year If                                | Under 24 Hrs.                          | 8. Date of Birth<br>(Month, Day         | ) 9                     | . Birthplace (State or Foreign                                               |
|                | Director                                                                                                                                               |                   | 155-22-4127 1□M 2점F                                                                                                                                | 77 Yrs.                | Months Days F                                     | Hours Min.                             | 6/1/193                                 |                         | Country)<br>[ew Jersey                                                       |
|                | nd<br>N                                                                                                                                                |                   | Usual Residence of Decedent           10a. State         10b. County         10                                                                    | Oc. City, Town or Lo   | ocation                                           |                                        |                                         |                         | 10d. Inside City Limits                                                      |
|                | //aryla                                                                                                                                                | ō                 |                                                                                                                                                    | Mitchellv              |                                                   |                                        |                                         |                         | 1 □Yes 2X No                                                                 |
|                | the 28a-                                                                                                                                               | Director          | 10e. Street and Number                                                                                                                             | IIICCIICIIV            | 10f. Zip Code                                     |                                        | 1                                       | 10g. Citizen of What    | at Country?                                                                  |
|                | h with                                                                                                                                                 |                   | 10450 Lottsford Rd. #2012                                                                                                                          |                        | 20721                                             |                                        |                                         | U.S.A.                  |                                                                              |
|                | ems                                                                                                                                                    | Funeral           | 11. Marital Status 12. Was Decedent Eve Armed Forces?                                                                                              | r in U.S. 13.          | Was Decedent of Hispa<br>If Yes, specify Cuban, I | anic Origin? (Spe<br>Mexican, Puerto I | cify Yes or No-<br>Rican, etc.)         | 14. Race -<br>Black,    | American Indian,<br>White, etc.                                              |
| 30             | or It                                                                                                                                                  | by Fu             | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:                                                                           |                        | 1 □ Yes 2 No S                                    | Specify:                               |                                         | Specify:                | White                                                                        |
| 2-003p         | d within 72 hours after death with the Maryland<br>giene.<br>Ir than "natural", or Items 23a or 28a-f show<br>the Medical Examiner must be notified at |                   | 15. Decedent's Education                                                                                                                           | 16a. Dece              | dent's Usual Occupation                           | on                                     |                                         | 16b. Kind of Busin      |                                                                              |
| 2 2            | within 72<br>iene.<br>• than "na<br>the Medic                                                                                                          | plet              | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)                                                             | (Give                  | kind of work done duri<br>DO NOT use retired)     | ing most of workir                     | ng                                      | Public S                | School -                                                                     |
| 7              | filed with<br>Hygiene<br>other the                                                                                                                     | Completed         | 4                                                                                                                                                  | T                      | eacher                                            |                                        |                                         | System                  |                                                                              |
| n<br>n         | be filk                                                                                                                                                | Be                | 17. Father's Name (First, Middle, Last)                                                                                                            |                        |                                                   | 3. Mother's Name<br>rene C. S          |                                         | Maiden Surname)         |                                                                              |
| Maryland       | es 1 and 2 should be filed v<br>of Health and Mental Hygie<br>f item 27 is marked other t<br>r other traumatic event, th                               | ပ                 | Michael Minalgo  19a. Informant's Name/Relationship (Type. Print)                                                                                  | 19b Maili              | ng Address (Street and                            |                                        |                                         |                         | ate. Zip Code)                                                               |
| <u>s</u>       | nd 2 s<br>Ith an<br>27 is r<br>trau                                                                                                                    |                   | James M. Lester, Son                                                                                                                               |                        | Fairfax Dr                                        |                                        |                                         | -                       | ,,                                                                           |
| ē,             | es 1 and 2<br>of Health<br>of item 27 i                                                                                                                |                   | 20a. Method of Disposition                                                                                                                         |                        | osition (Name of matory or other place)           |                                        | ate                                     | 20c. Location - C       | •                                                                            |
| altimore,      | Pag<br>nent<br>ant: I                                                                                                                                  |                   | Pagunal 2 Cremation 3 Removal from State                                                                                                           |                        | s Cemetery                                        | 1                                      | 2008                                    | East Bru<br>N           | nswick,<br>lew Jersey                                                        |
| Ball           | permit. Departr Importa any inji                                                                                                                       |                   | 21. Signature of Funeral Service Licensee                                                                                                          |                        | 2. Name and Address                               |                                        |                                         |                         | ltimore Avenue                                                               |
| _              | <u>v</u> ∪ = @ ol                                                                                                                                      |                   | 23a. Part1. Enter the disease, or complications that caused the                                                                                    |                        |                                                   |                                        |                                         |                         | ille, MD 20781                                                               |
|                |                                                                                                                                                        |                   | 23a. Part i. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final | e death. Do not en     | ter the mode of dying, s                          | such as cardiac c                      | respiratory ar                          | rest,                   | Approximate<br>Interval Between<br>Onset and Death                           |
|                | Physician /Medical                                                                                                                                     |                   | disease or condition resulting in death)  Myocard  Due to (or as a c                                                                               | ial Infar              | ction                                             |                                        |                                         |                         | 5 Minutes                                                                    |
|                | Examiner                                                                                                                                               |                   |                                                                                                                                                    | 511554451155 517       |                                                   |                                        |                                         |                         |                                                                              |
|                | D. F.                                                                                                                                                  |                   | Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury  Due to (or as a c                                            | onsequence of):        |                                                   |                                        |                                         |                         |                                                                              |
|                | ecute<br>and<br>-trans                                                                                                                                 | Examiner          | Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a c                                                        | consequence of):       |                                                   |                                        |                                         |                         |                                                                              |
| 8760,          | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit   |                   |                                                                                                                                                    | onsoquenes sij.        |                                                   |                                        |                                         |                         |                                                                              |
| 687            | ficate<br>g phys                                                                                                                                       | Physician/Medical | d                                                                                                                                                  |                        |                                                   |                                        |                                         | 5350 (16                |                                                                              |
| Box            | leath certific<br>attending p                                                                                                                          | In/M              | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf 1 □ Live birth 2                                                                     |                        | □Ectopic pregnancy                                |                                        |                                         | 23d. Date               | ,                                                                            |
|                | e deat<br>he atto<br>ed for                                                                                                                            | sicis             | In the past 12 months?  4 □ Pregnant at tin                                                                                                        |                        | Other (specify)                                   |                                        |                                         | Mont                    | h Day Year                                                                   |
| Р.<br>О        | nat the ded by the dedetached                                                                                                                          | Phy               | 9 ☐ Unknown  Part II. Other significant conditions contributing to death but r                                                                     | not resulting in the u | ınderiving cause given                            | in Part I                              | 23e. Did to                             | obacco use contrib      | oute to the cause of death?                                                  |
| Vital Records, | uires that<br>signed t<br>d be det                                                                                                                     | l by              | Peripheral Vascular Disease                                                                                                                        |                        |                                                   |                                        |                                         |                         | 3⊠ Probably 4 □Unknown                                                       |
| COL            | w require<br>been siç<br>should b                                                                                                                      | Completed         |                                                                                                                                                    |                        |                                                   |                                        | 24a. Was                                | an 24b. W               | ere autopsy findings available                                               |
| Re             | The lav                                                                                                                                                | duic              |                                                                                                                                                    |                        |                                                   |                                        | autor<br>perfo                          | rm <u>e</u> d?   de     | ere autopsy findings available ior to completion of cause of eath?  Yes 2 No |
| ta             |                                                                                                                                                        | Be C              | 25. Was case referred to medical                                                                                                                   |                        | 2                                                 | 26. Place of Deatl                     |                                         |                         | 163 2 100                                                                    |
| <u>r</u> <     | Physici<br>this ce<br>al direc                                                                                                                         | To B              | examiner? 1   Yes 2   X No   Hospital: 1   Inpatient                                                                                               | 2 ER/Outpatie          |                                                   | 4   Nursing Ho                         | me 5 🛚 Resi                             | dence 6 🗆 Other         | (Specify)                                                                    |
| Division or    | Attending Physician: r death. ector: After this certifics by the funeral director, p                                                                   | :io               | 27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day )                                                                      | Year) 28b. Time o      | Work?                                             | I                                      | 28d. Describe                           | how injury occurre      | d                                                                            |
| Sic            | Attend<br>er death<br>rector: /                                                                                                                        | icati             | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury                                                                       | / - At home, farm, st  |                                                   | es 2 No                                | 28f. Location (                         | Street and Numbe        | r or Rural Route Number,                                                     |
| <u>S</u>       | after<br>after<br>Direct                                                                                                                               | Certification:    | 4 Homicide determined building, etc.                                                                                                               | (Specify)              |                                                   |                                        | City or To                              |                         |                                                                              |
|                | To the Hospital or Attenwithin 24 hours after death To the Funeral Director:                                                                           |                   | 29a. Certifier  (Check only  29a Medical Examiner: On the basis of e                                                                               | my knowledge, dea      | ith occurred at the time                          | e, date and place,                     | and due to the                          | cause(s) and man        | ner as stated.                                                               |
|                | the H<br>nin 24<br>the Fi                                                                                                                              | Medical           | one) and manner state                                                                                                                              |                        |                                                   |                                        | Todati ille tillle,                     |                         |                                                                              |
|                | with                                                                                                                                                   | 2                 | 29b. Signature and title of contifier                                                                                                              |                        | 29c. License r                                    |                                        |                                         | _                       | (Month, Day, Year)                                                           |
| )              | $\overline{(n)}$                                                                                                                                       |                   | 30. Name and address of person who completed cause of dea                                                                                          | ath (Itom 22a) (Tuna   | D4760                                             | 13                                     |                                         | rebruary                | 13, 2008                                                                     |
| R              | (10)                                                                                                                                                   |                   |                                                                                                                                                    |                        | zenue, Mitc                                       | hellvil                                | le, MD                                  | 20721                   |                                                                              |
|                | St                                                                                                                                                     | ate               | 31 Date filed (Month Day Year) 32 Registrar'                                                                                                       | 's Signature           |                                                   |                                        |                                         |                         |                                                                              |
|                | Regist                                                                                                                                                 | rar               | FEB 1 4 2008                                                                                                                                       | . Arous                |                                                   |                                        |                                         |                         |                                                                              |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 18 16 3 5 6

|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     | For State Registrar                                                                                                               | State of Maryla                                                                   |                                                                                         | artment of H<br><i>rtificate of L</i>                                                 |                                                       |                                              | ené UUO<br>g. No.                             | 00000                                            |                          |                    |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------|-----------------------------------------------|--------------------------------------------------|--------------------------|--------------------|
|                | Physici                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     | 1. Decedent's Name (First, Middle, Last)  Mary Helen Mann                                                                         |                                                                                   |                                                                                         |                                                                                       |                                                       | 2. Date of Death<br>Month                    | Day Year                                      | 3. Time of Death                                 |                          |                    |
|                | /Medi<br>Examir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     | 4a. Facility Name (If not institution, give s                                                                                     | treet and number)                                                                 |                                                                                         | 4b. City, Town, or                                                                    | Location of Death                                     |                                              | 4c. County of Dea                             |                                                  |                          |                    |
|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     | Collington Episcop                                                                                                                | al Life Care                                                                      | <u> </u>                                                                                | Mitchel                                                                               | llville                                               |                                              | Prince (                                      | George's                                         |                          |                    |
|                | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | 5. Social Security Number 6. Sex 578−32−7735                                                                                      | M 2XF 7. Age (In yn                                                               | s. last birthday)<br>Yrs.                                                               | If Under 1 Year<br>Months Days                                                        | If Under 24 Hrs. Hours Min.                           | 8. Date of Birth<br>(Month, Day,<br>3/13/19: | Year) 9. Bir                                  | thplace (State or Foreign buntry) hington, DC    |                          |                    |
|                | pu »                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     | Usual Residence of Decedent  10a, State 10b, County                                                                               | 100 (                                                                             | Site Town and a                                                                         | ti                                                                                    |                                                       |                                              |                                               |                                                  |                          |                    |
|                | e Maryle<br>a-f shov<br>lifted at                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ctor                | Maryland Prince G                                                                                                                 |                                                                                   | Mitch                                                                                   | iellville                                                                             |                                                       |                                              |                                               | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No           |                          |                    |
|                | or 28                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Olre                | 10e. Street and Number                                                                                                            |                                                                                   |                                                                                         | 10f. Zip Code                                                                         |                                                       | 10                                           | g. Citizen of What Co                         | ountry?                                          |                          |                    |
|                | 23a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | la                  | 10450 Lottsford R                                                                                                                 | d                                                                                 |                                                                                         | 2072                                                                                  | 21                                                    |                                              | USA                                           |                                                  |                          |                    |
| 36             | s 1 and 2 should be filed within 72 hours after deeth with the Marylend if Health and Mental Hygiene Item 27 ie marked other then "natural", or items 23a or 28a-f show other treumatic event, the Mardical Examinar must be notified at                                                                                                                                                                                                                                                              | by Funeral Director | 11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced                                                              | 2. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: |                                                                                         | Was Decedent of Hi<br>f Yes, specify Cuba<br>1 ☐ Yes 2 🎇 No                           | spanic Origin? (Spe<br>n, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)             | 14. Race - Ame<br>Black, White<br>Specify:    |                                                  |                          |                    |
| Š              | 2 hou                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ted                 | 15. Decedent's Educ                                                                                                               | ation                                                                             | 16a. Deced                                                                              | dent's Usual Occupa                                                                   | ation                                                 | 1                                            | 6b. Kind of Business                          |                                                  |                          |                    |
| 21215-0036     | within 7<br>ene.<br>then "n                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Completed           | (Specify only highest grade<br>Elementary/Secondary (0-12)<br>12th                                                                | College (1-4or 5+)                                                                | life.                                                                                   | kind of work done of DO NOT use retired,  Manageme                                    | )                                                     |                                              | Federal (                                     | Government                                       |                          |                    |
| 9              | filed<br>Hygi<br>other<br>ent,                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | 17. Father's Name (First, Middle, Last)                                                                                           |                                                                                   | TISCAL                                                                                  | . Hanageme                                                                            | 18. Mother's Name                                     |                                              |                                               | 30VET IIIIEITC                                   |                          |                    |
| <u>a</u>       | lid be<br>lental<br>ked d                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | To Be               | Howard Mann                                                                                                                       |                                                                                   |                                                                                         |                                                                                       | Lore                                                  | tta McCa                                     | rten                                          |                                                  |                          |                    |
| Maryland       | 2 should be filed with<br>and Mental Hygiene.<br>Ie marked other ther<br>eumatic event, Ire M                                                                                                                                                                                                                                                                                                                                                                                                         |                     | 19a. Informant's Name/Relationship (Typ                                                                                           | e, Print)                                                                         | 19b. Mailir                                                                             | g Address (Street a                                                                   | and Number or Rura                                    | l Route Number,                              | City or Town, State,                          | Zip Code)                                        |                          |                    |
|                | 1 and 2<br>Health tem 27 I                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | Carol M. Pica/ Nie                                                                                                                |                                                                                   |                                                                                         | _                                                                                     |                                                       | ., Ft. W                                     | ashington,                                    | MD 20744                                         |                          |                    |
| ore            | ges 1<br>nt of He<br>if iten<br>or oth                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re                                                                        | 20b.                                                                              | Place of Dispo<br>cemetery, crer                                                        | sition (Name of<br>natory or other place                                              | 9)                                                    | ate 2                                        | Oc. Location - City or                        | Town, State                                      |                          |                    |
| Ë              | mit. Pages<br>partment of the cortent: If its<br>injury or or injury or or or injury or or or injury or or or injury or or or injury or or or injury or or or or injury or or or injury or or or injury or or or or or or or or or or or or or |                     | '4 ☐ Donation 5 ☐ Other (Specify)                                                                                                 | Mt                                                                                | . 01ive                                                                                 | t Cemeter                                                                             |                                                       |                                              | ashington,                                    |                                                  |                          |                    |
| Baltimore,     | permit. Page<br>Department o<br>Importent: If<br>any injury or<br>once.                                                                                                                                                                                                                                                                                                                                                                                                                               |                     | 21. Signature of Funeral Service Livense                                                                                          | 9                                                                                 |                                                                                         | Name and Addres                                                                       |                                                       |                                              | Kalas Fur<br>dgewater,                        |                                                  |                          |                    |
|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on                                                  | ations that caused the de<br>e cause on each line.                                | ath. Do not ent                                                                         | er the mode of dying                                                                  | g, such as cardiac o                                  | r respiratory arre                           | st.                                           | Approximate<br>Interval Between                  |                          |                    |
|                | Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     | Immediate Cause (Final disease or condition                                                                                       | Alzhe                                                                             | cner                                                                                    | 'v De                                                                                 | cco                                                   |                                              |                                               | Onset and Death                                  |                          |                    |
|                | /Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     | resulting in death)                                                                                                               | Due to (or as a conse                                                             | equence of):                                                                            |                                                                                       |                                                       |                                              |                                               |                                                  |                          |                    |
|                | LAdillile                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | _                   | Sequentially list conditions.                                                                                                     | Due to (or as a conse                                                             | nguanaa of).                                                                            |                                                                                       |                                                       |                                              |                                               |                                                  |                          |                    |
|                | ted<br>nsit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause pulsaase or injury that initiated events | Due to (or as a conse                                                             | equence on).                                                                            |                                                                                       |                                                       |                                              |                                               |                                                  |                          |                    |
| ,              | icate be executed<br>physician and<br>s the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                            | Exar                | that initiated events c. resulting in death) Last                                                                                 | Due to (or as a conse                                                             | equence of):                                                                            |                                                                                       |                                                       |                                              |                                               |                                                  |                          |                    |
| 68760,         | e be e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     | d                                                                                                                                 |                                                                                   |                                                                                         |                                                                                       |                                                       |                                              |                                               |                                                  |                          |                    |
| .89            | - 170 m                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | edical              |                                                                                                                                   |                                                                                   | 777                                                                                     |                                                                                       |                                                       |                                              |                                               | - 10.0                                           |                          |                    |
| .O. Box        | The law requires that the death certi<br>tle has been signed by the attending<br>tage 2 should be detached for use a                                                                                                                                                                                                                                                                                                                                                                                  | Physiclan/M         | ysiclan/M                                                                                                                         | ysiclan/M                                                                         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | c. If yes, outcome of preg<br>1 Live birth 2 Fe<br>4 Pregnant at time of<br>9 Unknown | tal death 3                                           | Ectopic pregnancy Other (specify)            |                                               |                                                  | 23d. Date of de<br>Month | livery<br>Day Year |
| Δ.             | ires that<br>signed by<br>d be deta                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | by                  | Part II. Other significant conditions con                                                                                         | ributing to death but not re                                                      | esulting in the u                                                                       | nderlying cause give                                                                  | n in Part I.                                          |                                              | acco use contribute to                        | the cause of death?                              |                          |                    |
| Ö              | w require<br>been si<br>should b                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ete                 | 11. 00                                                                                                                            | 3                                                                                 |                                                                                         |                                                                                       |                                                       | 24a. Was an                                  |                                               | Anna Cadina and Intelle                          |                          |                    |
| Vital Records, | : The lav                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Completed           | (a) free (                                                                                                                        |                                                                                   |                                                                                         |                                                                                       |                                                       | autopsy                                      | prior to death?                               | utopsy findings available completion of cause of |                          |                    |
| tal            | (0 17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | a)                  | 25. Was case referred to medical                                                                                                  |                                                                                   |                                                                                         |                                                                                       | 26. Place of Death                                    |                                              | Yes                                           | 2 □ No                                           |                          |                    |
| <u>&gt;</u>    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | OB                  | examiner? 1 \( \text{Yes}  2 \( \text{No} \)                                                                                      | ospital: 1 Inpatient 2                                                            | ☐ ER/Outpatien                                                                          | t 3 DOA Othe                                                                          |                                                       |                                              | nce 6 Other (Spe                              | cify)                                            |                          |                    |
| ion of         | ng<br>After                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | atlon: T            | 27. Manner of Death  1 Matural 5 Pending 2 Accident investigation                                                                 | 28a. Date of Injury<br>(Month, Day Year)                                          | 28b. Time of<br>Injury                                                                  | 28c. Injury<br>Work                                                                   | at 2                                                  | 28d. Describe hor                            |                                               | ,,                                               |                          |                    |
| Division       | el or Attend<br>s after death<br>il Director: /                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Certification:      | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined                                                                           | 28e. Place of Injury - At building, etc. (Spec                                    | home, farm, str                                                                         | eet, factory, office                                                                  | 1                                                     | 28f. Location (Str.<br>City or Town,         | eet and Number or Ri<br>State)                | ural Route Number,                               |                          |                    |
|                | To the Hospitel or Attendi<br>within 24 hours after death.<br>To the Funerel Director: A<br>completely filled in by the fu                                                                                                                                                                                                                                                                                                                                                                            | edical C            | 29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin                                                              | cian: To the best of my ki<br>er: On the basis of examinand manner stated.        | nowledge, death                                                                         | occurred at the time<br>restigation, in my op                                         | e, date and place, a<br>inion, death occurre          | and due to the caled at the time, da         | use(s) and manner as<br>te and place, and due | s stated.<br>to the cause(s)                     |                          |                    |
|                | To th<br>Withir<br>To th<br>comp                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Me                  | 29b. Signature and title of certifier                                                                                             | 1.1.                                                                              | mo                                                                                      | 29c. License                                                                          | number                                                | 29                                           | d. Date signed (Mont                          | h. Day, Year)                                    |                          |                    |
| )              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     | + Coment                                                                                                                          | *L W V                                                                            | 1.0                                                                                     | D25                                                                                   | 011                                                   |                                              | 2/2/0                                         |                                                  |                          |                    |
| 11             | CH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     | 30. Name and address of person who cor                                                                                            | npleted cause of death (Ite                                                       | em 23a) (Type,                                                                          | Print)                                                                                | w- P                                                  | ace,                                         | Lenten                                        | · one                                            |                          |                    |
| 77             | Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | te                  | 31. Date filed (Month, Day, Year)                                                                                                 | 32. Segistrar's Sign                                                              | nature                                                                                  | 1                                                                                     |                                                       |                                              | 100                                           |                                                  |                          |                    |
|                | Registr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | . 2                 | FEB 1 2 20                                                                                                                        | UO Platere                                                                        | J. 16                                                                                   | MALL                                                                                  |                                                       |                                              |                                               |                                                  |                          |                    |

|                     |                                                                                                                                                |                 | 1 - State O Registrar                                                                                                             | iviaryiari                                                   |                                      | rtificate of I                                                                             | ieaith and M<br><i>Death</i>                            | _                                          | eg. No. 2008                                               | 06357                                                 |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------|------------------------------------------------------------|-------------------------------------------------------|
|                     | Physici                                                                                                                                        |                 | Decedent's Name (First, Middle, Last)     Donald Edward Manz                                                                      |                                                              |                                      |                                                                                            | :                                                       | 2. Date of Dea<br>Month                    | th Day Year Year <b>9, 2008</b>                            | 3. Time of Death 12:45 PM                             |
|                     | /Medio                                                                                                                                         | A THAT          | 4a. Facility Name (If not institution, give street and nur<br>2003 Warners Terrace Nor                                            | nber)<br>Lh, Unit                                            | - 114                                | 4b. City, Town, or                                                                         | Location of Death Annapolis                             |                                            | 4c. County of Dea                                          |                                                       |
| Í                   | Funeral<br>Director                                                                                                                            |                 | 5. Social Security Number 213-64-4308 6. Sex                                                                                      | 7. Age (In yrs. 1                                            | last birthday)<br>Yrs.               | If Under 1 Year<br>Months Days                                                             | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Birth<br>(Month, Day<br>June 6, | 9. Bir<br>( <i>Year</i> ) 9. Bir<br>( <i>Ci</i><br>1953 Ne | thplace <i>(State or Foreign</i><br>ountry)<br>W York |
|                     | faryland<br>show<br>ed at                                                                                                                      | or              | Usual Residence of Decedent  10a. State  10b. County                                                                              |                                                              | 10d. Inside City Limits 1 □ Yes X No |                                                                                            |                                                         |                                            |                                                            |                                                       |
|                     | a or 28a-                                                                                                                                      | Il Director     | Maryland   Anne Arundel  10e. Street and Number  2003 Warners Terrace Nor                                                         |                                                              | nnapol<br>t 114                      | 10f. Zip Code<br>21401                                                                     | <u> </u>                                                | 1                                          | Og. Citizen of What Co                                     | ountry?                                               |
| 900                 | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>he Medical Examiner must be notified at | by Funeral      | 11. Marital Status  1 Never Married 2 Married  3 Widowed Married  12. Was Dec. Armed Fc 1 Yes 1 Yes 1 Yes 1 Yes 1 Yes 1 Yes 1 Yes | edent Ever in U.<br>orces?<br>2 No<br>ve XX<br>ates:         |                                      | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | ispanic Origin? (Spe<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)           |                                                            |                                                       |
| Maryland 21215-0036 | d within 72 ho<br>giene.<br>r than "natu<br>the Medical                                                                                        | Completed       | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (12)                         | 1-4or 5+)                                                    | 16a. Dece<br>(Give<br>life.          | dent's Usual Occup<br>kind of work done of<br>DO NOT use retired<br>Pressi                 | during most of worki<br>i)                              | ing                                        | 16b. Kind of Business                                      |                                                       |
| d 2                 | filed<br>Hygi<br>ther<br>ther                                                                                                                  | Be Co           | 17. Father's Name (First, Middle, Last)                                                                                           |                                                              |                                      | 110331                                                                                     | 18. Mother's Name                                       | (First, Middle,                            |                                                            |                                                       |
| ylar                |                                                                                                                                                | To E            | Edwin Manz                                                                                                                        |                                                              |                                      |                                                                                            | Alice Gar                                               |                                            |                                                            |                                                       |
|                     | s 1 and 2 should<br>f Health and Mer<br>tem 27 is marke<br>other traumatic                                                                     |                 | 19a. Informant's Name/Relationship (Type. Print) Mary Alice Manz / Sister                                                         |                                                              |                                      | ng Address <i>(Street</i><br>istol Dri                                                     |                                                         |                                            | r, City or Town, State,<br>laryland 21                     |                                                       |
| Baltimore,          | permit. Pages 1 a Department of He Important: If Item any Injury or othe                                                                       |                 | 20a. Method of Disposition  XXX Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)                            | Sinie I                                                      | 11cres                               |                                                                                            | dens 2/16                                               |                                            | 20c. Location - City or Annapolis,                         | Maryland                                              |
| Balt                | permit<br>Depart<br>Import<br>any in                                                                                                           |                 | 21. Signature of Funeral Service License                                                                                          |                                                              |                                      |                                                                                            |                                                         |                                            | ylor Funer<br>Annapolis                                    |                                                       |
|                     | Physician<br>/Medical<br>Examiner                                                                                                              |                 |                                                                                                                                   | caused the death<br>each line.                               | uence of):                           | Arter                                                                                      | disces                                                  | or respiratory am                          | rest,                                                      | Approximate Interval Between Onset and Death          |
| 68760,              | tificate be executed<br>g physician and<br>as the burial-transit                                                                               | edical Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events  c                                                         | (or as a conseq                                              | uence of):                           |                                                                                            |                                                         |                                            |                                                            |                                                       |
| .O. Box             | The law requires that the death certificate has been signed by the attending place 2 should be detached for use as t                           | Physician/Med   | in the past 12 months?                                                                                                            | tcome pf pregna<br>birth 2 ∐Feta<br>nant at time of d<br>own | al death 3                           | □Ectopic pregnance<br>□ Other (specify) _                                                  | ,                                                       |                                            | 23d. Date of de<br>Month                                   | elivery<br>Day Year                                   |
| rds, P              | w requires that<br>been signed to<br>should be deta                                                                                            | ρ               | Part II. Other significant conditions contributing to d                                                                           | eath but not res                                             | ulting in the u                      | nderlying cause giv                                                                        | en in Part I.                                           | 23e. Did to                                | obacco use contribute d'es 2 □ No 3 ☑ F                    | to the cause of death?<br>Probably 4 ∐Unknown         |
| Il Records,         | (0 17                                                                                                                                          | Completed       |                                                                                                                                   |                                                              |                                      |                                                                                            |                                                         |                                            | an 24b. Were a prior to death? 2 → 1 □ Ye                  |                                                       |
| Vital               | Physician: T<br>this certificat<br>ral director, pa                                                                                            | Be              | 25. Was case referred to medical examiner?                                                                                        |                                                              |                                      | ot 3D DOA Oth                                                                              | 26. Place of Deatl                                      |                                            |                                                            |                                                       |
| o                   | Ing<br>After<br>une                                                                                                                            | ition: To       | 27. Manner of Death 28a. Date                                                                                                     |                                                              | 28b. Time o<br>Injury                | f 28c. Injui                                                                               | 4 □ Nursing Ho                                          |                                            | lence 6 Other (Sp.                                         | ecify) -                                              |
| Division            | F = F                                                                                                                                          | Certification:  | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place build                                                             | e of injury - At ho<br>ing, etc. <i>(Specil</i>              | ome, farm, str                       | reet, factory, office                                                                      |                                                         | 28f. Location (S<br>City or Tow            | Street and Number or F<br>vn, State)                       | Rural Route Number,                                   |
|                     | To the Hospital of within 24 hours af To the Funeral D completely filled in                                                                    | Medical         | 29a. Certifier (Check only one)  1 Certifying Physician: To the to and man                                                        | e best of my kno<br>casis of examina<br>ner stated.          | owledge, deat<br>ation and/or ir     | th occurred at the tinvestigation, in my                                                   | me, date and place,<br>opinion, death occur             | and due to the red at the time,            | cause(s) and manner a<br>date and place, and du            | as stated.<br>ue to the cause(s)                      |
|                     | with To 1                                                                                                                                      | Σ               | 29b. Signature and title of certifier                                                                                             | -                                                            |                                      | 29c. Licens                                                                                | e number                                                |                                            | 29d. Date signed (Mor                                      |                                                       |
| 7                   | CII-                                                                                                                                           |                 | 30. Name and address of person who completed cau                                                                                  |                                                              |                                      | / /                                                                                        | T wite                                                  | 261                                        | 4                                                          | 71,2008                                               |
|                     | Sta<br>Registi                                                                                                                                 |                 | 31. Date filed (Month Day Year) 2 2008 32. F                                                                                      | gistrar's Signa                                              | Z H                                  |                                                                                            | 1 501/2                                                 | 291                                        | /thoup                                                     | i. NII                                                |

State of Maryland / Department of Health and Mental Hygiene? [] [] [ Certificate of Death

| Physician |
|-----------|
| /Medical  |
| Examiner  |

**Funeral** Director

Item 27 is marked other then "naturel", or Items 23s or 28s-f show other treumatic event, the Madical Exampler must be notified at and Mental Hygiene.

Completed by Funeral filed within 72 hours after Baltimore, Maryland 21215-0036 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sales 17. Father's Name (First, Middle, Last) Be 90 Joseph A. McGraw Jore, M.
Jermit. Peges 1 end 2 sho.
Department of Heatth of Important: if fear ony injury or entitle ony injury or entitle on the period of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original original original original original original original original original original original original original original original original original origi 19a. Informant's Name/Relationship (Type, Print) Robert A. McGraw / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/11/2008 Baltimore Crematory 21. Signature of Funeral Service Licensee Ment Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) signed by the attending physicien and dbe detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, Completed by should b certificate has birector, page 2 s 1 Yes or Attending Physician: within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be Other: 1 🗌 Yes 2500 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 15 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signat dittle of be 9+1

For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 8, 2008 8:20 A M Thomas Corcoran McGraw. Sr. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel 2520 Tudo Court Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign New York 8. Date of Birth Apr. 7, 1920 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) XXM 2□F 87 108-09-0014 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2 📉 📉 0 Directo Annapolis Anne Arundel Maryland| 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21401 United States 2520 Tudo Court 12. Was Decedent Ever in U.S. Armed Forces? 1 \$7\$ yes 2 □ No 1942— II #es. Give Year or Dates: 1945 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married X2 ▼ Married White 1 ☐ Yes 2XXVo Specify: 3 ☐ Widowed 4 ☐ Divorced 1945 16b. Kind of Business/Industry Industrial Equipment 18. Mother's Name (First, Middle, Maiden Surname) Mary O. Corcoran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 Thomas Point Ct. Annapolis, Maryland 21403 20c. Location - City or Town, State Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Day Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 26. Place of Death (Check only one, 4 Nursing Home 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred

31. Date filed (Month, Day, Year) State FEB 1 2 2008 Registrar

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9, 2008 3:15 A M February Charles Franklin Miller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Genesis Eldercare - Spa Creek Annapolis 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Dec. 25, 1936 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral 1 **→**M 2 □ F 371-36-9719 71 Director Missouri Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2 ☐ No Director Marvland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21409 603 Edwards Road United States Funeral 1 and 2 should be filed within 72 hours after death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 1954 — If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify White <u>م</u> 3 ☐ Widowed 4 X Divorced Year or Dates: 1962 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Petty Officer US Navv other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental H 27 is marked ott traumatic ever A.J. Miller Clara Iona Holloway ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Patricia A. Repke / Daughter 603 Edward Rd., Annapolis, Maryland Item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If It any injury or conce. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 2/11/08 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Fign war of Funeral Service License 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardias 5 minutes Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Completed by Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2X No To the Hospitallor Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death.

neral Director: / 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 3+1 fense thmy, crofton, mp 21114 6 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10, ZUVS John Kenneth Mann ebman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death . County of Death Examiner דעע בן Baltimore Washington Medical Center ni ar)
9. Birthplace (State or Foreign Country)
1924 West Virginia If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months 1 X M 2 □ F 83 235-34-7270 Director Aug. 01, Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Severn 1 ☐ Yes 2 No MD Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 751 Fawnelm Road 21144 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give V Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify Specify: Completed by WWII 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Church Minister 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lacy Wolford Andrew Brown Mann ဥ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 751 Fawnelm Road Severn, Maryland 21144 Nancy Marie Mann/ Wife permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Feb. 13, 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Veterans Cemetery 2008 Crownsville, MD 22. Name and Address of Facility Barranco & Sons, 21. Signature P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a confequence of) Examiner 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year ē in the past 12 months? 4 Pregnant at time of death Day 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No page 2 s has certificate 1 Yes Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I Director: After to in by the funeral Certification: or Attending (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide after Hospital within 24 hours To the Funeral Tecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a d title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type,

Registrar
DHMH 17 Rev 1/2001

State

TEV

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2008

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2/9/2008 Katherine Anna Miller 2244 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Prince George Laurel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) **Funeral** Days Year) Hours 1 M 200 92 4/5/1915 578-12-6239 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show a or 28a-f show be notified at 1 ☐ Yes 2KXNo Director MD Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7898 Bastille Place 21144 USA or than "natural", or items 23a the Medical Examiner must be Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify: <u>ک</u> 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n any injury or other traumatic event, the Media Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Lusby <u> Grace Daniels</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Robert Boyer 7110 Donston Dr. Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Purial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 2/15/2008 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) 1-2 days **Physician** Septicemia /Medical Due to (or as a consequence of): **Examiner** Aspiration Pneumonia 1-2 days Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed 1-2 days Azotema Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4□Pregnant at time of death 5 Other (specify) ned by the a 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, been signe should be o Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown C. Difficile, Colitis, Dementia, Atrial Fibrillation, HTN, DVT, Peripheral, Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ₹ No this 28a. Date of Injury (Month, Day Year) funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATTENDING 11,2008 FER PATSICI RW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Michael N. Baako, M.D.

FEB 1 2 2008

31. Date filed (Month, Day, Year)

7300 Van Dusen Rd.

32. Registrar's Signature

Laurel, MD 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per md 9877 3-24-08 vt amend item 2 state of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 U U 8 1. Decedent's Name (First, Middle, Last) 2 Date of Death February 2 **Physician** Doris M. Mason Doris Mason 9- 2008 7:22 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6984 Hanover Parkway Unit 300 Greenbelt Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 578-44-1472 76 Yrs. Director Oct 3 1931 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Director MarylandPrince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6984 Hanover Parkway Unit 300 20770 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Be Completed by 1 ☐ Yes 2X No Specify 3 □Widowed 4 □ Divorced Specify: Black Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Anne Arundel Elementary/Secondary (0-12) College (1-4or 5+) Food Service 10th Λ General Hospital permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other I any Injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Ago Hicks Grace Golden Matthews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20770 19a. Informant's Name/Relationship (Type. Print) Maxine Mason Lyons(Daughter) 6984 Hanover Parkway Unit 300 Greenbelt, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Scott Cemetery 2-15-08 Shady Side, Md. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Miniame Accessed & cilicons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 1. Krese 100483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestivo /Medical Due to (or as a nsequence of): Examiner Cerebrovascu Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or). The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit oronoun Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 1∐ Yes 2 1 No To the Hospital or Attending Physician: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of after death. 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 20062116 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEKLIT WORKNEH 7705 Belle Drive, Greenbelt, MD Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

| Charles William I                                                                                                                                                                                                                                                                                                     |               | 1- For State                                                    | State of Maryla                                  |                            | rtment of<br>tificate of            |                                          | d Mental                          |                                            | 2                                       | 008                           | 0636                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------|--------------------------------------------------|----------------------------|-------------------------------------|------------------------------------------|-----------------------------------|--------------------------------------------|-----------------------------------------|-------------------------------|-------------------------------------------|
| Physicia                                                                                                                                                                                                                                                                                                              |               | Registrar  1. Decedent's Name (First, Mic                       | ddle,Last)                                       |                            | imouto or                           | Douth                                    |                                   | 2. Date of De                              | ath                                     | 3.                            | Time of Death                             |
| Medical Examin                                                                                                                                                                                                                                                                                                        |               | Charles Will                                                    | iam Mander                                       |                            |                                     |                                          |                                   | Month<br>February                          | Day Yea<br>15, 2008                     | ır                            | 1258 hrs                                  |
| € "                                                                                                                                                                                                                                                                                                                   |               | 4a. Facility Name (if not institu<br>22680 Cedar Lane (         |                                                  | mber)                      | 4                                   | b. City, Town, or<br>Leonardtov          |                                   | eath                                       | 4c. County of St. Mary                  |                               |                                           |
| Funeral                                                                                                                                                                                                                                                                                                               |               | Social Security Number                                          |                                                  | 7. Age (In yrs. la         | ast birthday)                       | If Under 1 Yea                           |                                   | Hrs. 8, Date of B                          | lirth (MM/DD/YYYY                       |                               | ace (State or                             |
| Director                                                                                                                                                                                                                                                                                                              |               | 225-10-5085                                                     | 1 X M 2 F                                        | 97                         | Yrs.                                | Months Day                               |                                   |                                            | 3, 1910                                 | Foreign Countr                | Virginia<br>y)                            |
|                                                                                                                                                                                                                                                                                                                       |               | Usual Residence of Decedent                                     |                                                  |                            | 113.                                |                                          |                                   |                                            |                                         |                               |                                           |
| w any                                                                                                                                                                                                                                                                                                                 |               | 10a. State 10b. Coun                                            | •                                                | 10c. City,                 | Town or Location                    | on                                       |                                   |                                            |                                         |                               | d. Inside City Limits                     |
| rland<br>-f sho                                                                                                                                                                                                                                                                                                       | į             |                                                                 | St. Mary's                                       |                            |                                     |                                          | nardtov                           | √n                                         |                                         |                               | Yes 2 No                                  |
| e Mary<br>or 28a                                                                                                                                                                                                                                                                                                      | Director      | 10e. Street and Number                                          | ana Caunt                                        | ۸ ــ ا                     | 202                                 | 10f. Zip Code                            | 0650                              | ĺ                                          | 10g. Citizen of Wi                      | nat Country<br>JSA            | ?                                         |
| r death with the Maryland<br>or items 23a or 28a-f show<br>must be notified at once,                                                                                                                                                                                                                                  | eral D        | 22680 Cedar L                                                   |                                                  | Apt. 1                     |                                     |                                          |                                   | ( Specify Yes or N                         |                                         |                               | Indian, Black,                            |
| eath v                                                                                                                                                                                                                                                                                                                | nue           |                                                                 | Married Armed Fo                                 |                            |                                     | es, specify Cuba                         |                                   |                                            |                                         | e, etc.                       |                                           |
| after c                                                                                                                                                                                                                                                                                                               | by F          |                                                                 | Divorced If Yes, Give Yea                        | ır                         | 1                                   | Yes 2 X No                               | specify:                          |                                            | Specify:                                | Whit                          | e                                         |
| hours                                                                                                                                                                                                                                                                                                                 |               | 15. Decedent's Education (S                                     |                                                  |                            | 16a. Decedent                       | s Usual Occupa<br>est of working life    | ation (Give kind<br>e. DO NOT use | of work done<br>retired)                   | 16b. Kind of Bu                         | ısiness/Indu                  | ustry                                     |
| 36<br>nin 72<br>than "                                                                                                                                                                                                                                                                                                | ompleted      | Elementary/Secondary (0-1 1 2                                   | 2) College (1                                    | (-4 or 5+)                 |                                     | Lawyer                                   |                                   |                                            | Law                                     | Offic                         | e                                         |
| 15-0036<br>Iled within 77<br>Hygiene.<br>I other than                                                                                                                                                                                                                                                                 | Com           | 17. Father's Name (First, Midd                                  |                                                  |                            |                                     |                                          | 18.Mother's N                     | ame (First, Middle                         | , Maiden Surname                        | e)                            |                                           |
| 21215<br>vuld be file<br>Mental H<br>marked o                                                                                                                                                                                                                                                                         | Be (          | Frank T. Man                                                    |                                                  |                            |                                     |                                          | Li                                | llian R.                                   | Bell                                    |                               |                                           |
| D 21<br>should and Me                                                                                                                                                                                                                                                                                                 | မ             | 19a. Informant's Name/Relation                                  | Th                                               |                            | 4                                   | ,                                        |                                   |                                            | umber, City or Tow                      |                               |                                           |
| mand 2 sho ealth and rem 27 is traumat                                                                                                                                                                                                                                                                                |               | Laura E. Clarke 20a. Method of Disposition                      | Representa                                       |                            |                                     | Timberlin                                |                                   | Leonardt                                   | own, Maryla                             |                               |                                           |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. |               | 1 Burial 2 X Cremat                                             | _                                                | om State                   | crematory or oth                    | er place)                                | F                                 | ebruary 17                                 |                                         | •                             |                                           |
| Itin                                                                                                                                                                                                                                                                                                                  |               | 4 Donation 5 Other 21. Signature of Funeral Serv                |                                                  | Met                        | 22 N                                | n Cremator                               | s of Facility                     | 2008                                       |                                         |                               |                                           |
| Dem Dem Inju                                                                                                                                                                                                                                                                                                          |               | Muchael                                                         | F Sarch                                          | ne                         | Ma<br>P                             | attingley-<br>.O. Box 27                 | Gardiner<br>O Leona               | Funeral H                                  | ome, P.A.<br>20650                      |                               |                                           |
| Physician                                                                                                                                                                                                                                                                                                             |               | 23a. Part I. Enter the disease,<br>failure. List only one cau   |                                                  | aused the death            |                                     |                                          |                                   |                                            |                                         |                               | Approximate Interval<br>Between Onset and |
| /Medical<br>xaminer                                                                                                                                                                                                                                                                                                   |               | Immediate Cause (Final disea                                    | ase a. Atheroscler                               |                            |                                     | ease                                     |                                   |                                            |                                         |                               | Death                                     |
| `.                                                                                                                                                                                                                                                                                                                    |               | or condition resulting in death                                 | Due to (or as a                                  | consequence o              | f):                                 |                                          |                                   |                                            |                                         |                               |                                           |
|                                                                                                                                                                                                                                                                                                                       | je            | Sequentially list conditions, if any, leading to immediate      | Due to (or as a                                  | consequence o              | f):                                 |                                          |                                   |                                            |                                         |                               |                                           |
|                                                                                                                                                                                                                                                                                                                       | Examiner      | (Disease or injury that initiate events resulting in death) La: | d <sup>c.</sup>                                  | consequence o              | f):                                 |                                          |                                   |                                            |                                         | -                             |                                           |
| O,<br>e be executed<br>ysician and<br>burial - transit                                                                                                                                                                                                                                                                |               | - CVCIIIS (CSGIIIII) Ed.                                        | d                                                |                            |                                     |                                          |                                   |                                            |                                         |                               |                                           |
| O,<br>be exection a sucian a                                                                                                                                                                                                                                                                                          | dical         | UNPENDED                                                        | AMENDED                                          |                            |                                     |                                          |                                   |                                            |                                         |                               |                                           |
| 68760<br>certificate to<br>nding physise as the bu                                                                                                                                                                                                                                                                    | <b>a</b>      | IF FEMALE:<br>23b. Was decedent pregnant i                      | n the                                            | outcome of preg            |                                     | tal death 3                              | Fotosia es                        |                                            | 23d. Date o                             |                               | Voor                                      |
| Box 6876C<br>he death certificate<br>the attending physhed for use as the b                                                                                                                                                                                                                                           | cial          | past 12 months?                                                 | 4 Pregr                                          | nant at time of de         | ath                                 | tal death 3<br>her (Specify)             | Ectopic pr                        | egnancy                                    | Month                                   | Day                           | y Year                                    |
| Box<br>ie death of<br>the atter                                                                                                                                                                                                                                                                                       | hysi          | 1 Yes 2 No 9                                                    | 9 Ulikili                                        |                            |                                     |                                          |                                   |                                            |                                         |                               |                                           |
| Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u                                                                                                                                                                                                    | by P          | Part II. Other significant con                                  | ditions contributing to                          | o death but not r          | esulting in the u                   | inderlying cause                         | given in Part I                   |                                            | tobacco use cont                        |                               | e cause of death?                         |
| ds, l                                                                                                                                                                                                                                                                                                                 | ted           |                                                                 |                                                  |                            |                                     |                                          | <del></del>                       |                                            |                                         |                               | osy findings available                    |
| COFC<br>law re<br>has be                                                                                                                                                                                                                                                                                              | Completed     | ·                                                               |                                                  | ·                          |                                     |                                          |                                   | aut                                        | topsy                                   |                               | npletion of cause of                      |
|                                                                                                                                                                                                                                                                                                                       |               | 25. Was case referred to med                                    | tion                                             |                            |                                     | 26 Plac                                  | ce of Death (Ch                   | 1 Yes                                      | s 2 No                                  | 1 Yes                         | 2 No                                      |
| Division of Vital Records, the Hospital or Altending Physician: The law requir him 24 hours after ceath. the Funeral Director: After this certificate has been supplied in by the funeral director, page 2 should                                                                                                     | o Be          | examiner?  1 ✓ Yes 2 No                                         | Hospital:                                        | Inpatient 2                | ER/Outpatient                       |                                          | Other                             | ursing Home 5                              | Residence 6                             | ✓ Other: S                    | Scene                                     |
| n of \ding Phy.                                                                                                                                                                                                                                                                                                       | <u> </u>      | 27. Manner of Death                                             | 28a. Date                                        | of Injury<br>n, Day, Year) | 28b. Time of I                      | njury 28c. Inj                           | ury at Work?                      | 28d. Describ                               | e how injury occur                      | rred                          |                                           |
| Division<br>lator Attendi<br>safter ceath.                                                                                                                                                                                                                                                                            | ertification: |                                                                 | Pending                                          |                            |                                     | 1                                        | Yes 2 No                          | )                                          |                                         |                               |                                           |
| ivis<br>lor A<br>after<br>Direction by                                                                                                                                                                                                                                                                                | tific         | 3 Suicide 6 C                                                   | Could not be 28e. Place                          | ce of Injury - At h        | ome, farm, stree                    | et, factory, office                      | building, etc.                    | 28f. Location<br>or Town                   |                                         | ber or Rural                  | Route Number, City                        |
| Cospita<br>I hours<br>uneral                                                                                                                                                                                                                                                                                          | Ö             | 29a. Certifier                                                  | etermined (Specify)                              |                            |                                     |                                          | d-4 d -1                          |                                            |                                         |                               | <del> </del>                              |
| Division  To the Hospital or Attendit within 24 hours after ceath.  To the Funeral Director: A completely filled in by the fu                                                                                                                                                                                         | Medical       | (Check only                                                     | g Physician: To the bes<br>Examiner:On the basis | of examination a           | ge, death occui<br>ind/or investiga | red at the time, i<br>tion, in my opinic | date and place<br>on, death occur | , and due to the ca<br>red at the time, da | ause(s) and manne<br>ite and place, and | er as stated.<br>due to the o | cause(s)                                  |
| To To com                                                                                                                                                                                                                                                                                                             | Me            | 29b. Signature and title of cer                                 | and manner s                                     | stated.                    |                                     | 29c. Licer                               | nse number                        |                                            | 29d. Date sig                           | ned (Month                    | n, Day,Year)                              |
|                                                                                                                                                                                                                                                                                                                       |               | Por (                                                           | h - 12                                           | f Or                       | . ~                                 | 0.0                                      | .M.E.                             |                                            | February                                | 16, 2008                      |                                           |
|                                                                                                                                                                                                                                                                                                                       |               | 30. Name and address of per                                     |                                                  | •                          |                                     |                                          |                                   |                                            |                                         |                               |                                           |
| 10)db                                                                                                                                                                                                                                                                                                                 | 1 (1)         | Patricia Arnica-Po                                              |                                                  | ant Medical                |                                     | 111 Penn S                               | street, Balti                     | mbre, MD 212                               | 201                                     |                               |                                           |
| St                                                                                                                                                                                                                                                                                                                    |               | 31. Date filed (Month, Day, Ye                                  | 9 2008                                           | egistrar's Signati         | And a                               | K)                                       |                                   |                                            |                                         |                               |                                           |

|                                          | Phy<br>/M<br>Exa                                                                                                             | sicia:<br>edica<br>imine                                                                                                                                                                             |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| טוטוטון טו עולמו חפנטועא, ד.ט. סטא טסיט, | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. | To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit |

|                                                                                                                                                                                                              |                | 1- State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Depa | artment of Health and Nartificate of Death                                     | Mental Hygiene                                                               | 06364                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------|
| -                                                                                                                                                                                                            | £.             | Decedent's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | inodio oi bodiii                                                               | 2. Date of Death                                                             | 3. Time of Death                                   |
| Physic<br>/Med                                                                                                                                                                                               |                | Carl W. Morris, III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                | Month Day Year 02-08-2008                                                    | 7:31 A <sup>M</sup>                                |
| Exami                                                                                                                                                                                                        |                | 4a. Facility Name (If not institution, give street and number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4b. City, Town, or Location of Death                                           | **************************************                                       |                                                    |
|                                                                                                                                                                                                              |                | WOODSIDE CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Silver Spring                                                                  | Montgomery                                                                   |                                                    |
| Funeral                                                                                                                                                                                                      |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 14 M 2 F 7. The second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second | If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.                     | (Month Day, Year) Country                                                    |                                                    |
| Director                                                                                                                                                                                                     |                | 214-13-0347 Z7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | 07-03-1960 Wash.                                                             | , D.C.                                             |
| /land<br>ow                                                                                                                                                                                                  |                | 10a. State 10b. County 10c. City, Town or Lo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | cation                                                                         | 100                                                                          | d. Inside City Limits                              |
| Mar<br>a-f sh                                                                                                                                                                                                | ģ              | Maryland Montgomery Silver S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | pring                                                                          |                                                                              | 1 ∰Yes 2 ☐ No                                      |
| with the Marylanda or 28a-f show                                                                                                                                                                             | Director       | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 10f. Zip Code                                                                  | 10g. Citizen of What Countr                                                  | y?                                                 |
| ath wi                                                                                                                                                                                                       |                | 11530 Lockwood Drive #D1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 20904                                                                          | USA                                                                          |                                                    |
| ours after death v<br>ral", or items 23a<br>Examiner must                                                                                                                                                    | Funeral        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Was Decedent of Hispanic Origin? (Sp<br>If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No-<br>Di Rican, etc.) 14. Race - American<br>Black, White, et |                                                    |
| rs aft                                                                                                                                                                                                       | >              | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1 ☐ Yes 2 ☐ No Specify:                                                        | Specify: Blac                                                                | k                                                  |
| 2 hou<br>atura<br>cal E                                                                                                                                                                                      | bed            | 15. Decedent's Education 16a. Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | dent's Usual Occupation                                                        | 16b. Kind of Business/Indu                                                   |                                                    |
| be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at                                       | Completed      | (Specify only highest grade completed) (Give life. I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | kind of work done during most of work<br>DO NOT use retired)                   | king                                                                         |                                                    |
| ed wil                                                                                                                                                                                                       | Son            | 12th Se                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1f-employed                                                                    | Writer                                                                       |                                                    |
| tai H<br>d oth                                                                                                                                                                                               | Be             | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | ne (First, Middle, Maiden Surname)                                           |                                                    |
| hould<br>d Mer<br>narke<br>natic                                                                                                                                                                             | 은              | Carl W. Morris, Jr.  19a. Informant's Name/Relationship (Type. Print)  19b. Mailin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Marsha                                                                         | r I O y u ral Route Number, City or Town, State, Zip C                       | 2-4-1                                              |
| id 2 s<br>lith an<br>27 is r<br>traur                                                                                                                                                                        |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | Silver Spring, MD 2                                                          |                                                    |
| f Heal                                                                                                                                                                                                       |                | 20a Method of Disposition 20b. Place of Dispo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | Date 20c. Location - City or Tow                                             |                                                    |
| Page<br>nent o                                                                                                                                                                                               |                | 1 Abunal 2 Cremation 3 Hemoval from State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                | 8-2008 Suitland,Mar                                                          | vland                                              |
| permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural any injury or other traumatic event, the Medical Exponse. |                | 21. Signature of Funeral Service Licensee 22                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2. Name and Address of Facility                                                | ,                                                                            | <del>,</del>                                       |
| 9 9 5 5 8 8                                                                                                                                                                                                  |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | PA Ave. Suitland,MD                                                          | 20746                                              |
|                                                                                                                                                                                                              |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | er the mode of dying, such as cardiac                                          | or respiratory arrest,                                                       | Approximate<br>Interval Between<br>Onset and Death |
| Physician                                                                                                                                                                                                    | -              | Immediate Cause (Final disease or condition resulting in death)  aAdrenal Leukodystro                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | phy                                                                            |                                                                              | onoct and beaut                                    |
| /Medical<br>Examiner                                                                                                                                                                                         |                | Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                              |                                                    |
| 4                                                                                                                                                                                                            | ē.             | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |                                                                              |                                                    |
| cuted<br>d<br>ansit                                                                                                                                                                                          | Examiner       | if any, leading to immediate eause. Enter underlying Cause (Disease or injury that initiated events                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |                                                                              |                                                    |
| ate be executed hysician and the burial-transit                                                                                                                                                              |                | resulting in death) Last Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                              |                                                    |
| ate by                                                                                                                                                                                                       | dical          | d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                              |                                                    |
|                                                                                                                                                                                                              | Med            | IF FEMALE:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                              |                                                    |
| attend<br>for us                                                                                                                                                                                             | ian            | In the past 12 months?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Ectopic pregnancy Other (specify)                                              | 23d. Date of deliver                                                         | y<br>Day Year                                      |
| The law requires that the death certific the law requires that the death certific the has been signed by the attending page 2 should be detached for use as                                                  | Physician/Me   | 1 Yes 2 No 4 Pregnant at time of death 5 L<br>9 Unknown 9 Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                              |                                                    |
| that<br>ned b                                                                                                                                                                                                | 1              | Part II. Other significant conditions contributing to death but not resulting in the un                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | nderlying cause given in Part I.                                               | 23e. Did tobacco use contribute to the                                       | cause of death?                                    |
| quires<br>in sign                                                                                                                                                                                            | d by           | Severe Malnutrition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                | 1 ☐ Yes 2 ☐ No 3 ☐ Proba                                                     | bly 4 🗷 Unknown                                    |
| law requir<br>as been si<br>2 should                                                                                                                                                                         | plete          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | 24a. Was an 24b. Were autop                                                  | sy findings available                              |
|                                                                                                                                                                                                              | Completed      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | performed? death?                                                            | pletion of cause of<br>2□ No                       |
| sician: The<br>certificate<br>rector, pag                                                                                                                                                                    | Be (           | 25. Was case referred to medical examiner?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | th (Check only one)                                                          |                                                    |
| Physic<br>this c                                                                                                                                                                                             | 은              | 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | ome 5 ☐ Residence 6 ☐ Other (Specify)                                        | )                                                  |
| ding F                                                                                                                                                                                                       | ion            | 27. Manner of Death 1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No                                       | 28d. Describe how injury occurred                                            |                                                    |
| death death ctor:                                                                                                                                                                                            | licat          | 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, str                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | 28f. Location (Street and Number or Rural                                    | Route Number.                                      |
| al or safter                                                                                                                                                                                                 | Certification: | 4 ☐ Homicide determined building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | City or Tòwn, State)                                                         | ,                                                  |
| the Hospital or Attending Physician:<br>nin 24 hours after death.<br>the Funeral Director: After this certific<br>npletely filled in by the funeral director,                                                |                | 29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch | h occurred at the time, date and place                                         | e, and due to the cause(s) and manner as sta                                 | ated.                                              |
| To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu                                                                                   | Medical        | one) and manner stated.  29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 29c. License number                                                            | 29d. Date signed (Month, D                                                   |                                                    |
| o vit                                                                                                                                                                                                        |                | Same Choway                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | D0058965                                                                       | February 10,                                                                 |                                                    |
| 1                                                                                                                                                                                                            |                | 30. Name and address of person who completed cause of death (Item 23a) (Type,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | repluary 10,                                                                 | 2000                                               |
| (2)                                                                                                                                                                                                          |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | Rockville, MD 20852                                                          |                                                    |
|                                                                                                                                                                                                              | tate           | 31. Date filed (Month, Day, Year)  32. Registrar's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                              |                                                    |
| Regis                                                                                                                                                                                                        | trar           | FEB 14 2008 Kleans & Speck                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 7                                                                              |                                                                              |                                                    |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 20, 2008 February 2:00 aM Lu Glenda Nelson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** California 22669 Old Rolling Road St. Mary's Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗓 F Director 481-50-6182 62 11/30/1945 Iowa Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 Is marked other than "natural;" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar miles has marting as 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland | St. Mary's California 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 22669 Old Rolling Road 20619 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Hardware 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Johnson Bonnie Marie Athey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford W. Nelson/Husband 22669 Old Rolling Road, California, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gdns 2-23-2008 Leonardtown, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician renal cell caremon. month /Medical Due to (or as a consequence of) Examiner mg carcinoma months Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 21 No 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 | Inpatient 2 ER/Outpatient 3 DOA ٩ this funeral 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Born mo 2-21-08 address of person who completed cause of death (Item 23a) (Type, Print) Teffrey C. Brown mo from the Day, Year) 32 Registrar's Signature P.O. 664 31. Date filed (Month, Day, Year) State FEB 2 2 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav John Edward Oliver Sr. February 6 2008 2:51 A /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 455 Cornell Ct. Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Y June 21 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 9. Birthplace (State or Foreign **Funeral** Year) Months **1**▼ M 2 □ F Maryland 220-56-9757 54 Yrs 1953 Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Maryland Anne Arundel 1 ☐ Yes 2X No Director Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 455 Cornell Ct. 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ☐XNo Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel Co. and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Custodian Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe John Oliver Rose Queen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If Item 27 Is any Injury or other trau Rose Woodson(Sister) 7500 Ackerman Ct. Hanover, Md. 21076 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven 2-12-08 Glen Burnie, Md. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee WinNameRed & see of Eaci Sons Mortuary, 821 West St. Annapolis, Md. 21401 M00483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
4 YEAR Immediate Cause (Final disease or condition resulting in death) IABE TE **Physician** /Medical Due to (or as a consequence of) Examiner OBESI Sequentially list conditions, if any, leading to immediate cause. Enter unwerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2∏ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) spital or Attending Planus after death.

neral Director: After ti 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical прietely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID G. FREAS M.D. 2401 BRANDERMILL BLUD Registrar's Signature

Registrar

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day **Physician** 08, 5:30 P M 2008 William Penton Pitcher Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) July 13,1921 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1**X** M 2 □ F 86 Months Days Hours Min. 216-14-8718 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 10b. County la or 28a-f show t be notified at show MD Stevensville Oueen Anne's 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with USA 200 Terrapin Grove, Apt. 225 "natural", or items 23a 21666 Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) Press Feeder Can Company 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsie Veli Reed George Pitcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 200 Terrapin Grove, Apt. 225 Stevensville, MD 21666 Dolores H. Pitcher/ Wife Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Feb. 11, 2008 Baltimore, Maryland Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Barranco & Sons,
495 Gov. Ritchie 21. Signature of Funeral Sep Severna Park Funeral H Severna Park, MD 21146 P.A. Ritchie Hwy, Gov. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner death certificate be executed the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical r use as t IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0 9 Unknown contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions Division or Vital Records. Completed by 1 🗌 Yes 2200 3 ☐ Probably 4 ☐ Unknown been 24a. Was an autopsy performed2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 1∐ Yes -24 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 200 1 ☐ Yes 2 ER/Outpatient 3 DOA 은 this 28a. Date of Injury (Month, Day Year) funeral Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury 5 Pending investigation spital or Attendliours after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State

Registrar

30. Name and address of person

31. Date filed (Month, Day, Year)

0

**FEB 1 2 2008** 

who completed cause of death (Item 23a) (Type, Print)

32. Resstrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Joseph Warner 17, 2008 2:35 p Poe February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Yrs. Director 577-28-7906 84 10/05/1923 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. f show 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits "natural", or Items 23a or 28a-f shov edical Examiner must be notified at 1 TYes 2 No Director Maryland | St. Mary's Ridge 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 16296 Murray Road Funeral 20680 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No . If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ Specify: 3 Widowed 4 Divorced White er than "natura , the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) i. Pages 1 and 2 should be filed withment of Health and Mental Hygien tant; if item 27 is marked other the lury or other traumatic event, the Engineer <u>Telecommunication</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Joseph Vaughn Poe Lula G. Cookman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: if item 27 any injury or other th once. 16296 Murray Road, Ridge, MD Evelyn Poe/Wife 20680 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 02/22/2008 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician myelo dys plastic Years /Medical Due to (or as of consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by OUENIOND 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has , page 2 s autopsy performed' 2 110 Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 3 4/1 8 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3/19/48 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David M. Federle, M.D. 24035 Three Notch Road, Hollywood, MD 20636 31. Date filed (Month, Day, Year) State FEB 19 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** February 19, 2008 Joyce Anita Patton 8:03 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 F Director 038-24-0395 70 Sept. 19,1937 Rhode Island Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland St. Mary's **Mechanicsville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39600 Walnut Circle 20659 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No ģ Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond J. Zuleger Anita ဂ္ Bousquete 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie H. Patton, Sr./Spouse 39600 Walnut Cr., Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Brinsfield-Echols 2/23/2008 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 21. Signature of Funeral Service Ligense M00817 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MINUTES /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 2 Accident 1 Tes 2 🗆 No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Records, P.O. Box 68760 Division or Vital Hospital or Attending P 24 hours after death. Funeral Director: After t

show

?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other 1 any Injury or other traumatic event, the

the attending physician and hed for use as the burlal-tran

cate has been signed by the page 2 should be detach

certificate has

funeral director,

72 hours after death

Baltimore, Maryland 21215-0036

BYRON WDA

within 24 hours a
To the Funeral C Registrar

29b. Signature and title of certifier 30. Name

FEB 2 2

31. Date filed (Month, Day, Year)

29a. Certifier (Check only one) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

KOAD, LEONALDROWN, MD

D0062937

29d. Date signed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

2008

POINT LOCKOUT 25500

Registrar's Signature

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No UUR

| Physician |
|-----------|
| /Medical  |
| Examiner  |

CECELIA ELAINE RICHARDSON PROCTOR

2. Date of Death FEBRUARY 12, 2008 4:45 A M

5. Social Security Number 218-38-8997

1□M 2¬F Usual Residence of Decedent

7. Age (In yrs. last birthday)

If Under 1 Year | If Under 24 Hrs. Months Days Hours Min.

4b. City, Town, or Location of Death

8. Date of Birth AUGUST 13, 1941

9. Birthplace (State or Foreign WASHINGTON.D.C.

> 10d. Inside City Limits 1 ☐ Yes 2 No

**Funeral Director** 

ral", or items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or items 23s

item 27 is marked other other traumatic event, t

Important; If it any injury or c once,

Baltimore, Maryland 21215-0036

Director

Funeral

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10a. State MARYLAND

10e. Street and Number

CHARLES

4a. Facility Name (If not institution, give street and number)

10b. County

RESIDENCE. 9805 PROCTOR PLACE

10c. City, Town or Location WALDORF

> 10f. Zip Code 20603

WALDORF

10g. Citizen of What Country? UNITED STATES

4c. County of Death

CHARLES

9805 PROCTOR PLACE 11. Marital Status

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes 2 No Yes, Give Year or Dates:

66

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify

Black, White, etc. Specify: BLACK

14. Race - American Indian.

15. Decedent's Education (Specify only highest grade completed) 10TH GRADE

College (1-4or 5+)

(Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE

16a. Decedent's Usual Occupation

16b, Kind of Business/Industry HOME MAKER

Completed 17. Father's Name (First, Middle, Last) Be

ALOYISUS RICHARDSON

BEULAH AGATHA ROBINSON RICHARDSON

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type. Print) JOHN A. PROCTOR / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9805 PROCTOR PLACE, WALDORF, MARYLAND

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) ST. JOSEPH'S CHURCH Date 20c. Location - City or Town, State

pature of Funeral Sofwice Lisense

FEBRUARY 16,2008 POMFRET, MARYLAND TON FUNERAL HOME, P.A. LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

LYDIA C. THORNTON JOHNSON MO0583

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Physician /Medical Examiner

burial-transi

attending p

page 2 s

funeral director,

filled in by

completely

After 1

within 24 hours after death To the Funeral Director:

Exami

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Be Completed

Medical Certification: To

The law requires that the death certificate be executed

or Attending Physician;

Hospital

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

Due to (or as a consequence of): Due to (or as a consequence of):

Physician/Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4□Pregnant at time of death

3 □Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 70 24a. Was an autopsy perform

Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

3 Probably 4 □Unknown

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 ☐ Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D6052999

um my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10403 HOSPITAL DRIVE

IMI AN 31. Date filed (Month, Day, Year)

2008

32. Registrar's Signature

MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

29d. Date signed (Month, Day, Year)

MD CINTON 20735

|                                                                                                                                                                       | ,                             | 1- For State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / | artment of Health and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Mental Hygiene                                             | 2000 06271                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| Physicia<br>/Medic<br>Examin                                                                                                                                          | al                            | 1. Decedent's Name (First, Middle, Last)  Terry Kent Redcay  4a. Facility Name (If not institution, give street and number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4b. City, Town, or Location of Deat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2. Date of Death<br>Month Day<br>February 12               | 3. Time of Death                                                                                              |
| uneral                                                                                                                                                                |                               | 108 Leighton Avenue  5. Social Security Number 171-36-7742  6. Sex 1 M 2 F 7. Age (In yrs. last birthday)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Silver Spring  If Under 1 Year   If Under 24 Hrs  Months   Days   Hours   Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 8. Date of Birth<br>(Month, Day, Year)                     | ntgomery  9. Birthplace (State or Foreign Country) 46 Pennsylvania                                            |
| -,12                                                                                                                                                                  | ctor                          | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | reb 23, 19                                                 | 10d. Inside City Limits 1 □Yes 2 🛣 No                                                                         |
| Importants if them 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  | Completed by Funeral Director | 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1  | 10f. Zip Code 20901  Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2▼ No Specify:  dent's Usual Occupation kind of work done during most of work DO NOT use retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Specify Yes or Noto Rican, etc.)  16b. King                | zen of What Country?  14. Race - American Indian, Black, White, etc.  Specify: White Ind of Business/Industry |
| narked other                                                                                                                                                          | To Be Co                      | 12 Bookke  17. Father's Name (First, Middle, Last)  Stanley F. Redcay, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 18. Mother's Nar<br>Evelyn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | me (First, Middle, Maiden<br>Weik                          |                                                                                                               |
| I tem 27 is n                                                                                                                                                         |                               | Bruce D. Redcay/brother 108 I  20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place o | ng Address (Street and Number or Riceighton Avenue S. sistion (Name of matory or other place)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ilver Spring                                               |                                                                                                               |
| Important: If<br>any injury or<br>once.                                                                                                                               |                               | 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  GC  Chesapeal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | te Crematory 02/<br>2. Name and Address of Facility<br>2 ing Home Crematic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | on Service                                                 | sville, MD P.O. Box 784 rksville, MD 21029                                                                    |
| physician and edical sthe prival-transit                                                                                                                              | dical Examiner                | 23a. Part1. Enter the Assease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Linter to inderlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | c or respiratory arrest,                                   | Approximate Interval Between Onset and Death                                                                  |
| y the attending ph                                                                                                                                                    | Physician/Med                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | □Ectopic pregnancy<br>□ Other (specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2                                                          | 23d. Date of delivery<br>Month Day Year                                                                       |
| een signed b<br>nould be deta                                                                                                                                         | ۵                             | Part II. Other significant conditions contributing to death but not resulting in the u                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | nderlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | I.                                                         | se contribute to the cause of death?  ☐ No 3 ☐ Probably 4 ☐ Unknown                                           |
| rtificate has b<br>tor, page 2 sh                                                                                                                                     | e Completed                   | 25. Was case referred to medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 26. Place of De                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 24a. Was an autopsy performed?  1 Yes 2 No                 | 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No                   |
| To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as | ertification: To B            | examiner?  1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ott 3 DOA Other: 4 Nursing F  State of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | dome XXResidence 6 28d. Describe how injury                | y occurred  d Number or Rural Route Number,                                                                   |
| the Funeral                                                                                                                                                           | edical C                      | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deat  Check only one)  Certifying Physician: To the best of my knowledge, deat  and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | h occurred at the time, date and place<br>vestigation, in my opinion, death occ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | a, and due to the cause(s)<br>curred at the time, date and | and manner as stated. I place, and due to the cause(s)                                                        |
| LEO2                                                                                                                                                                  | M                             | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 29c. License number D48290                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                            | e signed ( <i>Month, Day, Year)</i><br>uary 14 <b>,</b> 2008                                                  |
| Star<br>Registra                                                                                                                                                      |                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Carlos E. Covarrubias, M.D. 8121 Georgest Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain S | ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Silver Spri                                                | ing, MD 20910                                                                                                 |

|                     |                                                                                                                                                                                                                                                       |                  | For<br>State<br>Registrar                                                                                                                                  | State of Marylar                                                                    |                                  | artment of I<br><i>rtificate of</i>                                    |                             |                                        |                              | ene 008                                   | 06372                                              |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------------------------------|-----------------------------|----------------------------------------|------------------------------|-------------------------------------------|----------------------------------------------------|
|                     | Physici                                                                                                                                                                                                                                               | an               | 1. Decedent's Name (First, Middle, Las                                                                                                                     | ,                                                                                   |                                  |                                                                        |                             | 2. Dat                                 | e of Death                   | Day Year                                  | 3. Time of Death                                   |
|                     | /Medic                                                                                                                                                                                                                                                | al               | Barbara  4a. Facility Name (If not institution, give                                                                                                       | Lee Riddle                                                                          |                                  | 4b. City, Town,                                                        | or Location                 | Feb                                    | ruary                        | 6,2008<br>4c. County of Dea               | 6:50 P M                                           |
|                     | Examir                                                                                                                                                                                                                                                | er               | 613 Truxton Road                                                                                                                                           | sacci and nambory                                                                   |                                  | Annap                                                                  |                             | or Death                               |                              | Anne Arun                                 |                                                    |
|                     | Funeral<br>Director                                                                                                                                                                                                                                   |                  | 210 40 2320                                                                                                                                                | 7. Age (In yrs.                                                                     | . last birthday)<br>Yrs.         | If Under 1 Year<br>Months Days                                         |                             | 24 Hrs. 8. Dat<br>Min. Mar             | e of Birth<br>onth, Day, Ye  | 9. Bir<br>1943 Mar                        | thplace (State or Foreign<br>yland                 |
|                     | /land<br>ow                                                                                                                                                                                                                                           |                  | Usual Residence of Decedent  10a. State 10b. County                                                                                                        | 10c. C                                                                              | ity, Town or Lo                  | ocation                                                                |                             |                                        |                              |                                           | 10d. Inside City Limits                            |
|                     | Ba-f sh                                                                                                                                                                                                                                               | ctor             | Maryland Anne Ar                                                                                                                                           | undel Ai                                                                            | napoli                           | S                                                                      |                             |                                        |                              |                                           | 1 □Yes XX                                          |
|                     | with the a or 2                                                                                                                                                                                                                                       | Funeral Director | 10e. Street and Number                                                                                                                                     |                                                                                     |                                  | 10f. Zip Code                                                          |                             |                                        |                              | . Citizen of What Co                      | -                                                  |
|                     | death                                                                                                                                                                                                                                                 | nera             | 613 Truxton Road 11. Marital Status                                                                                                                        | 12. Was Decedent Ever in L<br>Armed Forces?                                         | J.S. 13.                         | 21409 Was Decedent of If Yes, specify Cult                             | Hispanic Or                 | igin? (Specify Ye                      |                              | ited Stat                                 | erican Indian,                                     |
| Maryland 21215-0036 | iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at | d by Fu          | 1 □ Never Married 2 □ Married<br>3 □ Widowed 4 ▼ Divorced                                                                                                  | 1 Tyes Y No If Yes, Give X Year or Dates:                                           |                                  | 1 ☐ Yes 2 <b>X</b> XNo                                                 |                             |                                        | etc.)                        | Black, Whit                               | Mhite                                              |
| 15-(                | n 72 h<br>"natu<br>edical                                                                                                                                                                                                                             | lete             | 15. Decedent's Ed<br>(Specify only highest grad                                                                                                            |                                                                                     | 16a. Dece                        | dent's Usual Occu<br>kind of work done<br>DO NOT use retin<br>Zation R | pation<br>during mos        | st of working                          | 161                          | b. Kind of Business                       | /Industry                                          |
| 212                 | d withi<br>giene.<br>er than                                                                                                                                                                                                                          | Completed by     | Elementary/Secondary (0-12)                                                                                                                                | College (1-4or 5+)<br>5+                                                            | Utili<br>  Case                  | zation R<br>Manager                                                    | ĕview                       |                                        |                              | Nurse                                     |                                                    |
| pur                 | be file<br>ntal Hy<br>ad othe<br>event                                                                                                                                                                                                                | Be               | 17. Father's Name (First, Middle, Last)                                                                                                                    |                                                                                     |                                  |                                                                        |                             | er's Name (First,                      |                              | ,                                         |                                                    |
| aryla               | 12 should be filed within 7<br>h and Mental Hygiene.<br>7 is marked other than "n<br>traumatic event, the Medi                                                                                                                                        | 2                | Charles Heller  19a. Informant's Name/Relationship (7                                                                                                      | ype. Print)                                                                         | 19b. Mailii                      | ng Address (Stree                                                      | 1                           | e Meyd F                               |                              | City or Town, State,                      | Zip Code)                                          |
|                     | and 2<br>lealth a<br>m 27 is<br>her tra                                                                                                                                                                                                               |                  | Kathy L. Yff / Day                                                                                                                                         |                                                                                     |                                  | Edwards R                                                              |                             |                                        |                              |                                           |                                                    |
| nore                | ages 1<br>ent of H<br>t; If Ite<br>y or ot                                                                                                                                                                                                            |                  | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐                                                                                                   | nemoval mom state                                                                   |                                  | osition (Name of<br>matory or other pla                                |                             | Date                                   |                              | c. Location - City or                     |                                                    |
| Baltimore,          | permit. Pages 1 and 2<br>Department of Health a<br>Important: If Item 27 is<br>any Injury or other tra                                                                                                                                                |                  | 4 □ Donation 5 □ Other (Speciff 21. Signature of Fundral Service Licen                                                                                     |                                                                                     |                                  | Cremati  2. Name and Addr                                              |                             | 2/11/200<br>ity John M                 |                              | ltimore,<br>lor Funer                     | ral Home, Inc.                                     |
| B                   | S E E E                                                                                                                                                                                                                                               |                  | 1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/                                                                                                                     |                                                                                     |                                  |                                                                        |                             |                                        |                              |                                           | MD 21401                                           |
| 600                 | Physician                                                                                                                                                                                                                                             |                  | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of<br>Immediate Cause (Final                                                  |                                                                                     | th. Do not en                    |                                                                        |                             |                                        | ratory arrest                | t,                                        | Approximate<br>Interval Between<br>Onset and Death |
|                     | /Medical                                                                                                                                                                                                                                              |                  | disease or condition resulting in death)                                                                                                                   | a. Due to (or as a consec                                                           |                                  | N/                                                                     | Cani                        | er                                     |                              |                                           |                                                    |
| 15:                 | Examiner                                                                                                                                                                                                                                              | -                | Sequentially list conditions, if any, leading to immediate                                                                                                 | b. Due to (or as a conse                                                            | quence of):                      |                                                                        |                             |                                        |                              |                                           |                                                    |
|                     | cuted<br>nd<br>ransit                                                                                                                                                                                                                                 | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | С.                                                                                  | 4401100 017.                     |                                                                        |                             |                                        |                              |                                           |                                                    |
| 68760,              | icate be executed<br>physician and<br>s the burial-transit                                                                                                                                                                                            | al Ex            | resulting in death) Last                                                                                                                                   | Due to (or as a consec                                                              | quence of):                      |                                                                        |                             |                                        |                              |                                           |                                                    |
|                     | tificate<br>ig phys<br>as the                                                                                                                                                                                                                         | ledical          |                                                                                                                                                            | d                                                                                   |                                  | 114                                                                    |                             |                                        |                              |                                           |                                                    |
| Вох                 | The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit                                                                                     | Physician/M      | in the past 12 months?                                                                                                                                     | 23c. If yes, outcome pf pregr<br>1 □ Live birth 2 □ Fet<br>4 □ Pregnant at time of  | al death 3                       | Ectopic pregnand                                                       | ;y                          |                                        |                              | 23d. Date of de<br>Month                  | livery<br>Day Year                                 |
| P.O.                | it the d<br>by the<br>tached                                                                                                                                                                                                                          | hysic            | 1  Yes 2  No<br>9  Unknown                                                                                                                                 | 9□Unknown                                                                           | death 5L                         | Other (specify)                                                        |                             |                                        |                              |                                           |                                                    |
|                     | w requires that the di<br>been signed by the<br>should be detached                                                                                                                                                                                    | þ                | Part II. Other significant conditions of                                                                                                                   | ontributing to death but not re                                                     | sulting in the u                 | nderlying cause gi                                                     | ven in Part I               | I. 23                                  | e. Did tobac                 |                                           | o the cause of death?                              |
| Records,            | aw requ<br>s been<br>2 shoul                                                                                                                                                                                                                          | Completed        |                                                                                                                                                            |                                                                                     | -                                |                                                                        | -                           | 24                                     | a. Was an                    | 7                                         | utopsy findings available                          |
| E Re                |                                                                                                                                                                                                                                                       | Com              |                                                                                                                                                            |                                                                                     |                                  |                                                                        |                             | 10                                     | autopsy<br>performe<br>Yes 2 | d? prior to death?  ☑No 1 ☐ Yes           |                                                    |
| Vita                | Physician:<br>r this certifica<br>ral director, I                                                                                                                                                                                                     | Be               | 25. Was case referred to medical examiner?  1 Yes 2 No                                                                                                     | Hospital: 1 ☐ Inpatient 2 ☐                                                         | 15D/O + - *                      | . a==a Ot                                                              | h = = :                     | e of Death (Chec                       | -                            |                                           |                                                    |
| Division or Vital   | ding Phys                                                                                                                                                                                                                                             | n: To            | 27. Manner of Death  1 Natural 5 □ Pending                                                                                                                 | 28a. Date of Injury (Month, Day Year)                                               | 28b. Time o                      | IL SELECA                                                              | 4 LI N                      |                                        |                              | injury occurred                           | ecify)                                             |
| isio                | l or Attending<br>after death.<br>Director: After<br>I in by the fune                                                                                                                                                                                 | icatic           | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be                                                                                                    | 28e. Place of injury - At h                                                         |                                  | M 1                                                                    | Yes 2                       |                                        | nting (Chan                  |                                           | Section 1                                          |
| Div                 | tal or A<br>s after<br>al Direct                                                                                                                                                                                                                      | Certification:   | 4 ☐ Homicide determined                                                                                                                                    | building, etc. (Spec.                                                               | ify)                             | eet, factory, office                                                   |                             |                                        | y or Town, S                 |                                           | ural Route Number,                                 |
|                     | To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,                                                                                       | Medical          | 29a. Certifying Phy<br>(Check only<br>one) 2 Medical Exam                                                                                                  | /sician: To the best of my kn<br>Iner: On the basis of examin<br>and manner stated. | owledge, deat<br>ation and/or in | h occurred at the to<br>vestigation, in my                             | ime, date ai<br>opinion, de | nd place, and du<br>ath occurred at th | e to the caus                | se(s) and manner a<br>e and place, and du | s stated.<br>e to the cause(s)                     |
|                     | To t<br>To t                                                                                                                                                                                                                                          | Ź                | 29b. Signature and title of certifier                                                                                                                      | ^ w                                                                                 |                                  | 29c. Licen                                                             |                             | 0854                                   | 29d.                         | . Date signed (Mon                        |                                                    |
|                     | 3,                                                                                                                                                                                                                                                    |                  | 30. Name and address of person who o                                                                                                                       | X                                                                                   | m 23a) (Type.                    | Print)                                                                 |                             |                                        |                              |                                           | 2008                                               |
|                     | W                                                                                                                                                                                                                                                     |                  | Durid                                                                                                                                                      | Riseberg                                                                            | 2                                | 27                                                                     | >+ P.                       | n - 1                                  | Bal                          | fimore                                    | 21202                                              |
|                     | Sta<br>Registr                                                                                                                                                                                                                                        |                  | 31. Date filed (Month, Day, Year) FEB 1 2 200                                                                                                              | 3 Registrar's Sign                                                                  | ature                            | w. )                                                                   |                             |                                        |                              |                                           |                                                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 06373 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12, 2008 **Physician** 8:25 A. M February Robert Wade Sibole /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Lusby 12450 Dalton Court 8. Date of Birth (Month, Day, Year) 08–24–1938 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 □ F Washington, DC 69 Director 577–50–0331 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County orant; if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Calvert Lusby MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20657 12450 Dalton Court Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Affice 1 or 500 No If Yes, Give Year or Dates: 1956–1957 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 10 Inventor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ada Ester Tucker Robert Edward Sibole ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s nent of Health ar 629 Pelican Ave., Myrtle Beach, South Carolina 29577 Brenda J. Splawn (Sister) permit. Pages 1 and Department of Healt Important; if item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland Cedar Hill Cemetery 2/16/2008 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service License P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician - IVER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ~ KNOWL Sequentially list conditions, if any learning transcription cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by t. 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 740 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 202 has S page certificate 1∐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Peath 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After Natural 5 Pending investigation Iniury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled Hospital 29a. Certifier pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifier

LRW 10+1

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

John Barth, MD 110 Hospital Drive, Suite 310, Prince Frederick, Maryland 20678

30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)

₹ 2008▶

32. Registrans Signature

February 12, 2008

Anthony Siderchuk, Jr.

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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| Someth | - | - | 450 | - | way. |   |   |   |

|          |                                                                                                                                                                                                                                                                                                                       |               | - For State<br>egistrar                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Certifica                 | ate of De                               | ath                              |                    |                                      | Reg. N           | lo.               |                                         |
|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------------------|----------------------------------|--------------------|--------------------------------------|------------------|-------------------|-----------------------------------------|
| AL.      | Physicia                                                                                                                                                                                                                                                                                                              |               | I. Decedent's Name (First, Middl                                   | e,Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                           | _                                       |                                  |                    | 2. Date of<br>Month                  | f Death<br>Da    | y Year            | 3. Time of Death                        |
| ( 3 /    | া Examir                                                                                                                                                                                                                                                                                                              | ıer           | ANTHONY                                                            | Siderci                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | hak, Ji                   | R.                                      |                                  |                    | Febru                                | ary 12,          | 2008              | 0145 hrs                                |
| 7        |                                                                                                                                                                                                                                                                                                                       | 4             | a. Facility Name (if not institutio                                | n, give street and numb                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | er)                       |                                         | ty, Town, or L                   |                    | Death                                |                  | 4c. County of I   | Death                                   |
|          |                                                                                                                                                                                                                                                                                                                       |               | 1602 Washington Roa                                                | ıd                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                           | l W                                     | est Ministe                      | r                  |                                      |                  | Carroll           |                                         |
|          | Funeral                                                                                                                                                                                                                                                                                                               |               | 5. Social Security Number                                          | 6. Sex 7.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Age (In yrs. last birth   |                                         | Jnder 1 Year                     | If Under           |                                      | of Birth(N       |                   | 9. Birthplace (State or Foreign         |
|          | Director                                                                                                                                                                                                                                                                                                              |               | 218-46-9137                                                        | 1 LM 2 F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 59                        | Yrs. M                                  | onths Days                       | Hours              | Min.                                 | .27              | 1948              | Country)                                |
|          |                                                                                                                                                                                                                                                                                                                       | <u> </u>      | Jsual Residence of Decedent                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <u> </u>                  |                                         |                                  | L                  | 200                                  |                  | 1110              | ,,,,,                                   |
|          | any                                                                                                                                                                                                                                                                                                                   |               | 10a. State 10b. County                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 10c. City, Town           | or Location                             | <del>-</del> -                   |                    |                                      |                  |                   | 10d. Inside City Limits                 |
| 1        | _ & &                                                                                                                                                                                                                                                                                                                 |               | 0) 10                                                              | /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 41                        | /                                       | /                                |                    |                                      |                  |                   | 1 Yes 2 No                              |
| 0        | ylanc<br>P-f sh                                                                                                                                                                                                                                                                                                       | 휘             | 10e. Street and Number                                             | 2011                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10 857                    | + mins                                  | 7in Code                         |                    |                                      | 10a.             | Citizen of What   | t Country?                              |
| <u>ح</u> | Mar<br>7 28a<br>ed at                                                                                                                                                                                                                                                                                                 | Director      | rue. Street and Number                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0 /                       | 1 101                                   |                                  |                    |                                      | 1.03             | U.S               | 1                                       |
| =        | h the                                                                                                                                                                                                                                                                                                                 | Ē             | 1602 Wasi                                                          | LINGTON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Road                      |                                         |                                  | 57                 |                                      |                  |                   | . /C                                    |
|          | after death with the Maryland<br>'al'' or items 23a or 28a-f she<br>iner must be notified at once                                                                                                                                                                                                                     | Funeral       | 11. Marital Status                                                 | Armod Forc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ent Ever in U.S.          |                                         |                                  |                    | n? ( Specify Yes<br>Puerto Rican, et |                  | 14. Race - White, | American Indian, Black, etc.            |
|          | deatl                                                                                                                                                                                                                                                                                                                 | Ş١            |                                                                    | 1 Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2 No                      |                                         |                                  |                    |                                      |                  |                   | 11.10                                   |
|          | after all, c                                                                                                                                                                                                                                                                                                          | <u>6</u>      |                                                                    | orced If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                           |                                         | 2 No                             |                    |                                      |                  | Specify:          | WRITE                                   |
|          | ours                                                                                                                                                                                                                                                                                                                  | ٩             | 15. Decedent's Education (Spe                                      | cify only highest grade                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                           |                                         | sual Occupation  f working life. |                    | ind of work done<br>use retired)     | 16               | b. Kind of Busi   | ness/Industry                           |
|          | 0036 within 72 hours tiene. ner than "natur Medical Exam                                                                                                                                                                                                                                                              | Completed     | Elementary/Secondary (0-12)                                        | College (1-4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | or 5+)                    |                                         | -                                | _                  |                                      |                  | $\sim$            |                                         |
|          | O36                                                                                                                                                                                                                                                                                                                   | g             | 11                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           | Comp                                    | uter                             | Hog                | Name (First, Mi                      | e _              | BUS               | INESS                                   |
|          | ed w<br>tygie<br>othe                                                                                                                                                                                                                                                                                                 | 3             | 17. Father's Name (First, Middle                                   | , Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                           |                                         |                                  | - /                |                                      |                  | 4                 |                                         |
|          | 215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica                                                                                                                                                                                                                                              | Be            | ANTHONY SI                                                         | derchuk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | , S'R.                    |                                         |                                  | Ma                 | rgreti                               | ے کے             | Clark             | , State, Zip Code)                      |
|          | ID 21215-00; should be filed within and Mental Hygiene. T is marked other that it is matic event, the Med                                                                                                                                                                                                             | 의             | 19a. Informant's Name/Relations                                    | hip (Type, Print )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 191                       | b. Mailing Add                          | iress (Street                    | and Numb           | per or Rural Rou                     | te Numbe         | r, City or Town,  | , State, Zip Code)                      |
|          | imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.                            |               | Jacqueline P                                                       | indell-Sis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ter 11                    | 555/                                    | Kovum                            | ent 1              | Lake Cir                             | cle              | ac KSONY          | ille, FL                                |
|          | e, M<br>1 and 2<br>1 and 2<br>Health<br>Titem 2                                                                                                                                                                                                                                                                       |               | 20a. Method of Disposition                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | are made                  | and or other p                          | (Name of cen                     | 1                  | Date                                 |                  |                   | City or Town, State                     |
|          | ages int of it. If other                                                                                                                                                                                                                                                                                              |               |                                                                    | n 3 Removal from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | n State                   | (10000000000000000000000000000000000000 | mana to                          | 011                | 2-15-                                | 28               | Bultin            | DORE MI)                                |
|          | Saltim<br>sermit. Pag<br>Department<br>mportant:<br>njury or or                                                                                                                                                                                                                                                       | 1             | 4 Donation 5 Other S 21. Signature of Funeral Service              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Day                       | 22. Name                                | and Address                      | o acility          | Por alla                             | 201              | Der ha            | FULLEN                                  |
|          | Balt<br>permit.<br>Departi<br>Import<br>injury                                                                                                                                                                                                                                                                        |               | 1 - A U / / A                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1455                      | 1600                                    | 76                               | 1 21               | 21/11/1                              | (111)            | Sychology         | FUNERAL  ROLLIZZA  Approximate Interval |
| K.4.     | Physician                                                                                                                                                                                                                                                                                                             | -             | 23a. Part I. Enter the disease, o                                  | r complications that cau                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ised the death. Do no     | ot enter the m                          | ode of dying,                    | such as ca         | ardiac or respirat                   | ory arrest       | s lock, or hear   | representate interven                   |
| 4        | Medical                                                                                                                                                                                                                                                                                                               | - 1           | failure. List only one cause                                       | e on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           |                                         |                                  |                    |                                      |                  |                   | Between Onset and<br>Death              |
|          | _xaminer                                                                                                                                                                                                                                                                                                              |               | Immediate Cause (Final disease or condition resulting in death)    | e a. Atherosc.<br>Due to (or as a c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | lerotic card              | 10vascu                                 | lar dise                         | ase                |                                      |                  |                   |                                         |
|          |                                                                                                                                                                                                                                                                                                                       | l             |                                                                    | bue to (or as a c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | onsequence or).           |                                         |                                  |                    |                                      |                  |                   |                                         |
|          |                                                                                                                                                                                                                                                                                                                       | ē             | Sequentially list conditions, if any, leading to immediate         | Due to (or as a c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | onsequence of):           |                                         |                                  |                    |                                      |                  |                   |                                         |
|          |                                                                                                                                                                                                                                                                                                                       | Ë             | cause. Enter Underlying Cause<br>(Disease or injury that initiated | c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                           |                                         |                                  |                    |                                      |                  |                   |                                         |
|          | - t                                                                                                                                                                                                                                                                                                                   | Examiner      | events resulting in death) Last                                    | Due to (or as a c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | onsequence of):           |                                         |                                  |                    |                                      |                  |                   |                                         |
|          | ecute<br>and<br>tran                                                                                                                                                                                                                                                                                                  |               |                                                                    | d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                           |                                         |                                  |                    |                                      |                  |                   |                                         |
|          | frate be executed g physician and the burial - transit                                                                                                                                                                                                                                                                | n/Medical     | X UNPENDED                                                         | - 4# <b>E</b> SBE,27.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ,perME,g877,              | 3/3/08                                  | TT                               |                    |                                      |                  |                   |                                         |
|          | 760<br>ficate b<br>g physics<br>s the bu                                                                                                                                                                                                                                                                              | ₩.            | IF FEMALE:                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | atcome of pregnancy       |                                         | r                                |                    |                                      |                  | 23d. Date of      |                                         |
|          |                                                                                                                                                                                                                                                                                                                       | ian/          | 23b. Was decedent pregnant in<br>past 12 months?                   | Live bill                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | th<br>nt at time of death |                                         |                                  | Ectopic            | pregnancy                            |                  | Month             | Day Year                                |
|          | Box 68 e death certif the attending ted for use as                                                                                                                                                                                                                                                                    | siciar        | 1 Yes 2 No 9 Ur                                                    | nknown g Unknow                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           | 5 Other                                 | (Specify)                        |                    |                                      |                  |                   |                                         |
|          | P.O. Box 68: that the death certifine ned by the attending detached for use as!                                                                                                                                                                                                                                       | ≥             | Part II. Other significant cond                                    | Company of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s |                           | na in the unde                          | rlving cause o                   | iven in Pa         | rt I. 236                            | e. Did toba      | acco use contril  | bute to the cause of death?             |
|          | P.O es that the igned by be detac                                                                                                                                                                                                                                                                                     | ģ             | Turk ii. Other signmount osha                                      | tions oomanboung to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                           | · • · · · · · · · · · · · · · · · · · · | .,,                              |                    |                                      | Yes              | 2 No 3            | ✔ Probably 4 Unknown                    |
|          | ords, P.C. w requires that as been signed be should be deta                                                                                                                                                                                                                                                           |               |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           |                                         |                                  |                    | 124:                                 | a. Was an        | 1.24b. V          | Vere autopsy findings available         |
|          | w req                                                                                                                                                                                                                                                                                                                 | olet          |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           |                                         |                                  |                    |                                      | autopsy          | p                 | rior to completion of cause of leath?   |
|          | Reco<br>The law<br>icate has<br>page 2 s                                                                                                                                                                                                                                                                              | Completed     |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           |                                         |                                  |                    | 1                                    | perform<br>Yes 2 |                   | Yes 2 No                                |
|          | tal Rection: The                                                                                                                                                                                                                                                                                                      | ŭ             | 25. Was case referred to medic                                     | al                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                           |                                         |                                  |                    | (Check only one                      | )                |                   |                                         |
|          | Vital hysician: this certiful director,                                                                                                                                                                                                                                                                               | e Be          | examiner?<br>1 ✓ Yes 2 No                                          | Hospital: 1 In                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | patient 2 ER/0            | Outpatient 3                            | DOA                              | Other <sub>4</sub> | Nursing Home                         | 5 R              | esidence 6        | Other: Scene                            |
|          | of \langle Phy After the uneral                                                                                                                                                                                                                                                                                       |               | 27. Manner of Death                                                | 28a. Date o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | of Injury 28b.            | . Time of Injur                         | y 28c. Inju                      | ry at Work         | ? 28d. De                            | scribe ho        | w injury occurre  | ed                                      |
|          | ion of<br>tending Pt<br>eath.<br>or: After<br>the funeral                                                                                                                                                                                                                                                             | Ö             | 1 X Natural 5 Per                                                  | nding (Month, I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Day, Year)                |                                         | 1                                | Yes 2              | No                                   |                  |                   |                                         |
|          | Visic<br>or Atte<br>after dea<br>Directo                                                                                                                                                                                                                                                                              | cat           |                                                                    | estigation 28e, Place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | of Injury - At home,      | farm, street, f                         | actory, office t                 | uilding, et        | tc. 28f. Lo                          | cation (Str      | eet and Number    | er or Rural Route Number, City          |
|          | Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be                                                                                                                                | Certification | det                                                                | uld not be ermined (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                           |                                         | •                                |                    | or '                                 | Town, Sta        | te)               |                                         |
|          | Ospital hours a lineral li                                                                                                                                                                                                                                                                                            |               | 4 Homicide  29a. Certifier 1 Contifuing 1                          | Physician: To the best                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | of my knowledge de        | anth occurred                           | at the time d                    | ate and nls        | ace and due to t                     | he cause         | (s) and manner    | as stated.                              |
|          | Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | ical          | (Check only 1 Certifying I                                         | aminer:On the basis of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | f examination and/or      | investigation                           | in my opinior                    | n, death oc        | curred at the tim                    | e, date ar       | nd place, and d   | lue to the cause(s)                     |
| سد_      | To t<br>To t                                                                                                                                                                                                                                                                                                          | Medical       | 29b. Signature and title of certif                                 | and manner sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ated.                     |                                         | 29c. Licens                      |                    |                                      |                  |                   | ed (Month, Day, Year)                   |
|          |                                                                                                                                                                                                                                                                                                                       | 2             | 250. Signature and title of certif                                 | 11 -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10                        |                                         | O.C.                             |                    |                                      |                  | February 1        |                                         |
|          |                                                                                                                                                                                                                                                                                                                       |               | Joish                                                              | e Jeo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1 mg                      | _                                       | 0.0.                             | IA1· □ •           |                                      |                  |                   | _,                                      |
|          |                                                                                                                                                                                                                                                                                                                       |               | 30. Name and address of person                                     | ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                           | )                                       | 01-                              | Dalki              | ma MD 0400                           | 14               |                   |                                         |
|          |                                                                                                                                                                                                                                                                                                                       |               | Tasha Greenberg Mi                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | edical Examiner           | 111 Pe                                  | enn Street,                      | Dalumo             | ore, MD 2120                         |                  |                   |                                         |
|          | S                                                                                                                                                                                                                                                                                                                     | tate<br>trar  | 31. Date filed (Month, Day, Year                                   | 32 Reg                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | gistrar's Signature       | Legal                                   | 2                                |                    |                                      |                  |                   |                                         |

**ORIGINAL** 

OCME &

| Greg     | јогу Е. Stir                                                                                                                                                                                                                                                                                                                                                                              | nch              | 1              | - For State                                                       | State                | of Maryland /                               |               | artment of                       |                              |                | Menta               | al Hyg           |                           | J               | 200                    | 18                | 0637                                       |
|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------|-------------------------------------------------------------------|----------------------|---------------------------------------------|---------------|----------------------------------|------------------------------|----------------|---------------------|------------------|---------------------------|-----------------|------------------------|-------------------|--------------------------------------------|
|          | Physic                                                                                                                                                                                                                                                                                                                                                                                    | iar              | _              | egistrar<br>I. Decedent's Nam                                     |                      |                                             |               |                                  |                              |                |                     |                  | . Date of Dea             |                 | Year                   | 1                 | of Death                                   |
| Med      | lical Exam                                                                                                                                                                                                                                                                                                                                                                                | nine             |                |                                                                   | y E. Sti             | nchcomb  ve street and number)              |               |                                  | 4b. City, To                 |                | action of           |                  | Month<br>February         |                 | ounty of Deatl         |                   | ) hrs                                      |
| *        |                                                                                                                                                                                                                                                                                                                                                                                           |                  |                | ,                                                                 | Bottom Road          | ,                                           |               | i                                | Annap                        |                | cation of           | Dealli           |                           |                 | e Arundel              |                   |                                            |
|          | Funera                                                                                                                                                                                                                                                                                                                                                                                    |                  |                | 5. Social Security N                                              |                      | Sex 7. Age                                  | e (In yrs. la | ast birthday)                    | If Under                     | 1 Year<br>Days | If Under<br>Hours   | 24Hrs.<br>Min.   | 8. Date of Bi             | rth(MM/DD/      | YYYY) 9. Bir<br>Forei  | an                |                                            |
|          | Directo                                                                                                                                                                                                                                                                                                                                                                                   | r                | L              | 218-94-0                                                          | 12                   | <b>∠</b> M 2 F                              | 43            | Yrs                              |                              | Days           | nours               | MITI.            | April                     | 12 19           | 64 <sup>Cd</sup>       | ountry)Ma         | ryland                                     |
|          | any                                                                                                                                                                                                                                                                                                                                                                                       |                  | <b>⊢</b>       | Usual Residence o<br>10a. State                                   | 10b. County          |                                             | 10c. City,    | Town or Loca                     | tion                         |                |                     |                  |                           |                 |                        | 10 <b>d. In</b> s | ide City Limits                            |
|          | <b>*</b>                                                                                                                                                                                                                                                                                                                                                                                  | 1441             | ۱,             | MD                                                                | Anne Ar              | undel                                       | Ar            | napoli                           | s                            |                |                     |                  |                           |                 |                        | 1 🔲               | res 2 X No                                 |
| 2        | Maryla<br>- 28a-f                                                                                                                                                                                                                                                                                                                                                                         | -                | Director       | 10e. Street and Nu                                                |                      |                                             | _             | 04.5                             | 10f. Zip 0                   |                |                     |                  |                           | 10g. Citizen    | of What Cou            | intry?            |                                            |
| 1166     | AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 its marked other than "natural", or items 23a or 28a-f show maric event, the Medical Evaniteer must be notified at once.                                                                                                                                                           | 1                |                | 11. Marital Status                                                | MIII BOC             | tom Road, 1                                 |               |                                  |                              | 1401           | nic Origi           | n? (Sne          | cify Yes or No            | n- 14           | USA<br>Race - Ame      | rican India       | n Black                                    |
| $\equiv$ | eath w                                                                                                                                                                                                                                                                                                                                                                                    |                  | Funeral        | 1 X Never Marri                                                   | ied 2 Marrie         | Armed Forces?                               |               |                                  | es, specify                  |                |                     |                  |                           | , ,             | White, etc.            | riodit indic      | , Diook,                                   |
|          | ت . ت                                                                                                                                                                                                                                                                                                                                                                                     | 4I .             |                | 3 Widowed                                                         |                      | ed If Yes, Give Year<br>or Dates:           |               | 1                                | Yes 2                        |                |                     |                  |                           |                 |                        | ite               |                                            |
|          | hours "natur                                                                                                                                                                                                                                                                                                                                                                              |                  | ed<br>Led      | 15. Decedent's E<br>Elementary/Sec                                |                      | only highest grade com<br>College (1-4 or 5 |               | 16a. Decede<br>during n          | nt's Usual O<br>nost of work |                |                     |                  |                           | 16b. Kind       | of Business            | /Industry         |                                            |
|          | thin 72 than 'than                                                                                                                                                                                                                                                                                                                                                                        |                  | Completed      | 12                                                                | ordary (0-12)        | College (1-4 of t                           | 5.,           |                                  | Ch                           | ef             |                     |                  |                           |                 | Resta                  | auran             | it                                         |
|          | 5-0036<br>iled within 7<br>Hygiene.<br>I other than                                                                                                                                                                                                                                                                                                                                       |                  | 히              | 17. Father's Name                                                 | •                    |                                             |               |                                  |                              | 18             |                     |                  | First, Middle,            |                 | rname)                 |                   |                                            |
|          | 2121<br>buld be fi<br>Mental<br>marked                                                                                                                                                                                                                                                                                                                                                    | 1                | To Be          | Earl Et                                                           | ugene St:            |                                             |               | 19b. Mailir                      | na Address                   | (Street a      |                     |                  | Pennir                    |                 | or Town, Stat          | e, Zip Cod        | de)                                        |
|          | MD 3                                                                                                                                                                                                                                                                                                                                                                                      |                  |                |                                                                   | B. Nilse             |                                             |               | 1                                | o<br>on Ber                  |                |                     |                  |                           | everna          | Park                   | , MD              | 21146                                      |
|          | re, les land f. Healt liftem                                                                                                                                                                                                                                                                                                                                                              |                  |                | 20a. Method of Dis                                                |                      | Removal from Sta                            | - 1           | Place of Dispo<br>crematory or o |                              | e of ceme      | etery,              | Feb.             | Date 22                   |                 | ation - City o         |                   | tate                                       |
|          | Pages 1 a ment of He tant: If ite                                                                                                                                                                                                                                                                                                                                                         |                  |                | 4 Donation 5                                                      | Other Speci          | fy:                                         |               | bury U                           |                              |                | Z                   | Feb.<br>20       |                           | Z               | Arnold                 | , MD              |                                            |
|          | Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Infine 71 stanked other than "natural" infine 72 is marked other than "natural" infine or other fearmants event, the Medical Examin                                                                                                                          |                  |                | 21. Signature of Fi                                               | neral Service Lic    | ensee                                       |               | 22.<br>  Ba                      | Name and A                   | Address of     | Sons                | , P.             | A. Se                     |                 |                        |                   | ral Hom                                    |
|          | Physicia                                                                                                                                                                                                                                                                                                                                                                                  | 17               | - 1            | 23a. Part I. Enter t                                              | he disease, or cor   | nplications that caused                     | the death     | n. Do not enter                  | 95 GOV<br>the mode of        | dying, s       | uch as ca           | e Hw<br>rdiac or | respiratory a             | rest, shock     | Park<br>or heart       | Appro             | 21146<br>eximate Interval<br>een Onset and |
| 5        | /Medica                                                                                                                                                                                                                                                                                                                                                                                   |                  | 1              | Immediate Cause                                                   |                      | each line.<br>a. Upper gasti                | rointe        | stinal h                         | emorrha                      | ne             |                     |                  |                           |                 |                        | Detw              | Death                                      |
| ٠,       |                                                                                                                                                                                                                                                                                                                                                                                           |                  | -              | or condition result                                               |                      | Due to (or as a conse                       | equence o     | of):                             |                              |                |                     |                  |                           |                 |                        |                   |                                            |
|          |                                                                                                                                                                                                                                                                                                                                                                                           | ı                | Ē              | Sequentially list or<br>if any, leading to it<br>cause. Enter Und | mmediate             | Due to (or as a cons                        | equence o     | of):                             |                              |                |                     |                  |                           |                 |                        |                   |                                            |
|          |                                                                                                                                                                                                                                                                                                                                                                                           |                  | Examiner       | (Disease or injury events resulting in                            | that initiated       | c.<br>Due to (or as a cons                  | equence o     | of):                             |                              |                |                     |                  | _                         |                 |                        | 1-                |                                            |
|          | ),<br>be executed<br>sician and                                                                                                                                                                                                                                                                                                                                                           | 1                |                |                                                                   |                      | d                                           | <u> </u>      |                                  |                              |                |                     |                  |                           |                 |                        |                   |                                            |
|          | O,<br>e be ex<br>ysician                                                                                                                                                                                                                                                                                                                                                                  | onlia            | edical         | X UNPENDED                                                        |                      | #23a_PII.2                                  | 27.per        | ME.C877,                         | 3/4/08                       | 3 TT           |                     | _                |                           | 224 1           | Date of delive         |                   |                                            |
|          | Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physician in the Funeral After this certificate has been signed by the attending physician in the funeral directors and directors are the himself. | as IIIc          |                | IF FEMALE:<br>23b. Was deceden<br>past 12 month                   |                      | 23c. If yes, outcome 1 Live birth           | me ot preg    |                                  | etal death                   | 3              | Ectopic             | pregnar          | ісу                       |                 | Date of delive<br>onth | Day               | Year                                       |
|          | Box 6 steath cer the attendial                                                                                                                                                                                                                                                                                                                                                            | in in            | <u>ත</u>       | 1 Yes 2                                                           |                      | wn 9 Unknown                                | t time of de  | eath 5 C                         | Other (Spec                  | ify)           |                     |                  |                           |                 |                        |                   |                                            |
|          | that the de                                                                                                                                                                                                                                                                                                                                                                               | 9 I              | 췹              | Part II. Other sign                                               | nificant condition   | s contributing to deat                      | th but not    | resulting in the                 | underlying                   | cause giv      | ven in Pa           | rt I.            | 23e. Did                  | tobacco us      | e contribute t         | to the cau        | se of death?                               |
|          | ires the signed                                                                                                                                                                                                                                                                                                                                                                           |                  | g p            | chron                                                             | nic alcohol          | ism                                         |               | ·                                |                              |                |                     |                  | 1 🗌 Y                     | es 2 1          | No 3 Pr                | obably 4          | Unknown                                    |
|          | cords, P.O. law requires that the has been signed by the detached                                                                                                                                                                                                                                                                                                                         | mous .           | Completed      |                                                                   |                      |                                             | _             |                                  |                              |                |                     |                  |                           | opsy            | prior to               | completi          | ndings available<br>on of cause of         |
|          | Reco                                                                                                                                                                                                                                                                                                                                                                                      | 4                | E O            |                                                                   |                      |                                             |               |                                  |                              |                |                     |                  | 1 🗸 Yes                   | formed?<br>2 No | death?                 |                   | 2 No                                       |
|          | ing Physician: The law requir<br>Mafter this certificate has been s                                                                                                                                                                                                                                                                                                                       | 100              | Be             | 25. Was case refe examiner?                                       |                      | Hospital:                                   | ent 2         | ER/Outpatie                      |                              |                | of Death (<br>Other |                  | nly one)<br>Home 5        | Residenc        | e 6 V Oth              | er: Scene         |                                            |
|          | of V<br>g Phys<br>fter thi                                                                                                                                                                                                                                                                                                                                                                | leral o          | 빍              | 1 ✓ Yes<br>27. Manner of Dea                                      | 2 No<br>ath          | 28a. Date of Inju                           | ury           | 28b. Time of                     |                              | J.,            | at Work             |                  | 28d. Describ              |                 |                        |                   | <del></del>                                |
|          | ion<br>trendiin<br>leath.<br>tor: A                                                                                                                                                                                                                                                                                                                                                       | al l             | 턣              | 1 X Natural 2 Accident                                            | 5 Pending            |                                             | Teal)         |                                  |                              | 1 Y            | es 2                | No               |                           |                 |                        |                   |                                            |
|          | Division tal or Attendit is after death.                                                                                                                                                                                                                                                                                                                                                  | Illied in by the | Certification: | 3 Suicide                                                         | 6 Could n            | ot be 28e. Place of Ir                      | njury - At I  | home, farm, str                  | eet, factory,                | office bu      | iilding, et         | C.               | 28f. Location<br>or Town, |                 | i Number or I          | Rural Rou         | te Number, City                            |
|          | Hospital<br>24 hours<br>Funeral                                                                                                                                                                                                                                                                                                                                                           |                  |                | 4 Homicide<br>29a. Certifier                                      |                      | ician: To the best of m                     | ny knowler    | dae death occ                    | urred at the                 | time dat       | e and nia           | ce and           | due to the ca             | use(s) and      | manner as st           | ated.             |                                            |
|          | To the Hospita within 24 hours To the Funeral                                                                                                                                                                                                                                                                                                                                             | naiduic          | Medical        | (Check only one) 2 ✓                                              | Medical Exami        | ner:On the basis of exa                     | amination     | and/or investig                  | ation, in my                 | opinion,       | death oc            | curred at        | the time, da              | te and place    | e, and due to          | the cause         | e(s)                                       |
|          | To To                                                                                                                                                                                                                                                                                                                                                                                     | 3                | \$             | 29b. Signature and                                                | d title of certifier | 1 00 0                                      |               |                                  | 29c                          | . License      |                     |                  |                           |                 | ite signed (A          |                   | /,Year)                                    |
|          | _                                                                                                                                                                                                                                                                                                                                                                                         |                  |                | Car                                                               | ion t                | talla                                       |               |                                  |                              | O.C.N          | 1.E.                |                  |                           | Febru           | uary 20, 2             | 8<br>             |                                            |
|          | BL                                                                                                                                                                                                                                                                                                                                                                                        | di               | ) [            | 30. Name and add<br>Carol Allan                                   |                      | no completed cause of<br>stant Medical Exa  |               | <sup>m 23a)</sup><br>111 Penn    | Street, E                    | Baltimo        | re, MD              | 21201            | I                         |                 |                        |                   |                                            |
|          |                                                                                                                                                                                                                                                                                                                                                                                           | Sta              | _              | 31. Date filed (Mo                                                |                      |                                             | ar's Signa    | ture                             | last.                        | •              |                     |                  |                           | · -             |                        |                   |                                            |
| C        | Reg                                                                                                                                                                                                                                                                                                                                                                                       |                  |                |                                                                   | FEB 25               | 2008                                        |               | OPICIN                           | Al                           |                |                     |                  |                           |                 |                        |                   | <u> </u>                                   |
| U        | TIMES IN INC.                                                                                                                                                                                                                                                                                                                                                                             | 1120             | υI             |                                                                   |                      |                                             |               | ORIGIN                           | AL.                          |                |                     |                  |                           |                 |                        |                   |                                            |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 9,2008 1315 Daisy Lee Smith February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Clinton Southern Maryland Hospital Prince Georges If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 ☑ F 63 Director 29,1944 Մulv VA 227-58-1196 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural"; or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Md. PG Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 4301 Delmar Avenue United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Sales Executive Private 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be ment of Health and Menta ant: If item 27 is marked Laura Williams McKinley Perkins or other traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7711 Argonaut Street
Severn Md. 21144

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date Jerome Smith/son 20a. Method of Disposition 20c. Location - City or Town, State 3 □Removal from State 1 ☑ Burial 2 ☐ Cremation permit. Page Department o Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Park 2/14/08 Landover, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TOTA inknow Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Physician/Medical the IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day for in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed be be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 | Yes 2 | No 3 | Probably 4 | Chrisnown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 Physician: 25. Was case referred to redical director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 1 N Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Division or Vital Hospital or Attending hours after deatl uneral Director: To the Hospital c within 24 hours af To the Funeral D completely filled in

Baltimore,

P.O. Box 68760.

Records,

5

State Registrar

Date filed (Month, Day, 2008 14

and title of

29a. Certifier (Check only one)

29b. Signatur



erson who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Leading Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

|                                                                                     |                   | State Registrar  1. Decedent's Name (First, Midd                                                                                                          | fle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  |                                                         | Cer                         | tificate of                                                        |                                      | 2. Date              | Reg. No                                     | No. E.                              | 08                                    | 0 6 3 7                                        |
|-------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------|-----------------------------|--------------------------------------------------------------------|--------------------------------------|----------------------|---------------------------------------------|-------------------------------------|---------------------------------------|------------------------------------------------|
| ysicia                                                                              | n                 | The teams of net, while                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ne A.                                                            | Samue1                                                  |                             |                                                                    |                                      | Mon                  |                                             | Day<br>08                           | Year                                  | 2:03 p. M                                      |
| Medica<br>camine                                                                    | A CONTRACTOR      | 4a. Facility Name (If not institution                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |                                                         |                             | 4b. City, Town,                                                    | or Location of De                    |                      |                                             | 4c. County                          | of Death                              | -1                                             |
|                                                                                     |                   | 7923 Orchard                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  | 7. 6 "                                                  | lane to the                 | Bowie                                                              | 1811-2-                              | Iro I                |                                             | Prince                              |                                       | orge's                                         |
| eral<br>ctor                                                                        |                   | 5. Social Security Number 578-82-3083                                                                                                                     | 6. Sex                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | M 21∑F                                                           | 7. Age (In yrs. I<br>84                                 |                             | If Under 1 Year<br>Months Days                                     |                                      | lin. (Moi            | e of Birth<br>nth, Day, Yea<br>2/1923       | ar)                                 | 9. Birthp<br>Cour<br>Toba             |                                                |
|                                                                                     |                   | Usual Residence of Decedent  10a. State 10b. Count                                                                                                        | v                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  | 10c City                                                | y, Town or Lo               | cation                                                             |                                      |                      |                                             |                                     | 11                                    | 10d. Inside City Limit                         |
| ed at                                                                               |                   |                                                                                                                                                           | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | mant.                                                            |                                                         |                             |                                                                    |                                      |                      |                                             |                                     |                                       | 1 X Yes 2 □ N                                  |
| notif                                                                               | rect              | MD Princ  10e. Street and Number                                                                                                                          | .e 6e(                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | orge's                                                           | WOd                                                     | 15                          | 10f. Zip Code                                                      |                                      |                      | 10g. (                                      | Citizen of V                        | What Cour                             | ntry?                                          |
| any injury or other traumatic event, the Medical Examiner must be notified at once. | o e               | 7923 Orchard                                                                                                                                              | Park                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Way                                                              |                                                         |                             | 20715                                                              |                                      |                      |                                             | S.A.                                |                                       |                                                |
| er mr                                                                               | Funeral Director  | 11. Marital Status                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  | edent Ever in U.s                                       | S. 13. V                    | Was Decedent of<br>f Yes, specify Cul                              | Hispanic Origin?                     | (Specify Yes         | s or No-                                    | 14. Rac                             | ce - Americ                           |                                                |
| am l                                                                                | by Fu             | 1 Never Married 2 Ma                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 ☐ Yes<br>If Yes, Giv                                           | 2 X No<br>re                                            |                             | 1 □ Yes 2 No                                                       |                                      |                      | •                                           | Specify                             |                                       |                                                |
| : Ex                                                                                |                   | 3₺Widowed 4 ☐ Divorce                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Year or Da                                                       | ates:                                                   | 16a Dagga                   | dent's Usual Occu                                                  | pation                               |                      | 165                                         | . Kind of Bu                        | рте                                   |                                                |
| Wedi.                                                                               | plet              | (Specify only high                                                                                                                                        | est grade                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | completed)                                                       | -Aor E . \                                              | (Give                       | kind of work done  OO NOT use retire                               | during most of                       | working              |                                             |                                     |                                       | ,                                              |
| i i                                                                                 | Completed         | Elementary/Secondary (0-12)                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | College (1                                                       | -U 0+)                                                  |                             | е Кеереі                                                           | , i                                  |                      | P1                                          | rivat                               | e Res                                 | sidence                                        |
| , leave                                                                             | Be C              | 17. Father's Name (First, Middle                                                                                                                          | e, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                  |                                                         |                             |                                                                    | 18. Mother's I                       | Name (First,         | Middle, Maio                                | len Surnan                          | me)                                   |                                                |
| ا ا                                                                                 | 년<br>-            | Simeon Anthon                                                                                                                                             | J                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  |                                                         |                             |                                                                    |                                      | Joseph               |                                             |                                     |                                       | _                                              |
|                                                                                     | .4                | 19a. Informant's Name/Relation                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | •                                                                |                                                         |                             | ng Address (Stree                                                  |                                      |                      |                                             | -                                   |                                       | p Code)                                        |
| <u>.</u>                                                                            | (i)-              | Vilma Clermont 20a. Method of Disposition                                                                                                                 | , Dau                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ıghter                                                           | 20b. P                                                  | Place of Dispo              | Orchard sition (Name of                                            | i                                    | y, Bow               |                                             | D 207                               |                                       | own State                                      |
| 5                                                                                   |                   | 1X Burial 2 ☐ Cremation                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | moval from                                                       | State c                                                 | cemetery, crer              | natory or other pl                                                 | · ·                                  |                      |                                             |                                     |                                       | •                                              |
| Cinfu                                                                               | r                 | 4 □ Donation 5 □ Other ( 21. Signature of Funeral Service                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | , 7                                                              | Gat                                                     |                             | Leaven Co                                                          |                                      | 2/16/                | 112 20 12 12 12 12                          |                                     |                                       | ring, MD                                       |
| any ir                                                                              |                   | Day of Interior Service                                                                                                                                   | 4 LIVETISE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1                                                                | isch                                                    |                             | sch's Fu                                                           |                                      | ome. P               |                                             |                                     |                                       | imore Aven<br>Le, MD 207                       |
|                                                                                     | $\dashv$          | 23a. Part1. Enter the disease, of shock, or heart failure. Lis                                                                                            | or complic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ations that c                                                    | aused the death                                         | h. Do not ent               | er the mode of dy                                                  | ing, such as car                     | diac or respir       |                                             |                                     |                                       | Approximate<br>Interval Between                |
| the burial-transit                                                                  | dical Examiner    | Sequentially list conditions, if any, leading to immediate cause. Enter Undarying Cause (Disease or injury that initiated events resulting in death) Last | c.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                  | or as a consequ                                         | ,                           |                                                                    |                                      |                      |                                             |                                     |                                       |                                                |
| should be detached for use as the                                                   | n/Medit           | IF FEMALE:<br>23b. Was decedent pregnant                                                                                                                  | 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                  | come pf pregna                                          |                             | Total:                                                             | -                                    |                      |                                             | 23d. Da                             | ate of deliv                          | rery                                           |
| ached lor                                                                           | Physician/Me      | in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  | oirth 2  Feta<br>nant at time of d<br>own               |                             | ⊒Ectopic pregnan<br>∃Other (specify)                               | СУ                                   |                      |                                             |                                     | lonth                                 | Day Year                                       |
| 100                                                                                 |                   | Part II. Other significant condi                                                                                                                          | itions cont                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | tributing to de                                                  | eath but not res                                        | ulting in the u             | nderlying cause g                                                  | iven in Part I.                      | 23                   | le. Did tobac                               | co use con                          | ntribute to                           | the cause of death?                            |
|                                                                                     | ed b              | Coronary Arte                                                                                                                                             | ry D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | isease                                                           | , Hyper                                                 | tensio                      | n                                                                  |                                      | _                    | 1 ☐ Yes                                     | 2□ No                               | 3 □ Pro                               | obably 4 ∑Unknov                               |
| 2                                                                                   | Completed by      |                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |                                                         |                             |                                                                    |                                      | -                    | ia. Was an<br>autopsy<br>performed<br>Yes 2 | d?                                  | prior to co                           | topsy findings availab<br>ompletion of cause o |
| 1                                                                                   |                   | 25. Was case referred to medic examiner?                                                                                                                  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  |                                                         |                             |                                                                    |                                      | Death (Chec          |                                             |                                     |                                       |                                                |
|                                                                                     | m                 |                                                                                                                                                           | H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  | Inpatient 2                                             |                             | " 3 DOA                                                            |                                      | ng Home 5            |                                             |                                     |                                       | ify)                                           |
|                                                                                     | To Be             | 1 ☐ Yes 2 ☒ No                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 28a. Date                                                        | of Injury<br>th, Day Year)                              | 28b. Time o<br>Injury       | W                                                                  | uryat<br>ork?<br>⊒Yes 2 ⊒No          |                      | escribe how i                               | injury occu                         | ırred                                 |                                                |
|                                                                                     | 은                 | 27. Manner of Death 1 ☑ Natural 5 ☐ Pend                                                                                                                  | ding                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (101011                                                          |                                                         |                             | ivt 1                                                              | ∠ ∐ N0                               |                      |                                             |                                     |                                       |                                                |
|                                                                                     | 은                 | 27. Manner of Death 1 ☑ Natural 5 ☐ Pence 2 ☐ Accident inves 3 ☐ Suicide 6 ☐ Could                                                                        | stigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 28e. Place                                                       | of injury - At ho<br>ing, etc. <i>(Specit</i>           | ome, farm, sti              | reet, factory, offic                                               | e                                    | 28f. Loc<br>Cit      | cation (Stree<br>ty or Town, S              | t and Num<br>itate)                 | nber or Rui                           | ral Route Number,                              |
|                                                                                     | Certification: To | 27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier  1 Certify  1 Certify                                                   | stigation id not be irmined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 28e. Place<br>build<br>ician: To the<br>ier: On the b            | ing, etc. <i>(Specit</i><br>e best of my kno            | <i>fy)</i><br>owledge, deat | reet, factory, office<br>th occurred at the<br>envestigation, in m | time, date and p                     | Cit<br>place, and du | ty or Town, S                               | State)<br>se(s) and m               | manner as                             | stated.                                        |
|                                                                                     | 은                 | 27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier                    | stigation Id not be rmined  ying Physical Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 28e. Place<br>build<br>ician: To the<br>ier: On the b<br>and man | ing, etc. (Specit<br>best of my kno<br>basis of examina | <i>fy)</i><br>owledge, deat | th occurred at the                                                 | time, date and p                     | Cit<br>place, and du | ty or Town, S te to the caus he time, date  | State) se(s) and me and place       | manner as<br>e, and due               | stated.                                        |
|                                                                                     | Certification: To | 27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier                    | stigation Id not be Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Immined Im | 28e. Place<br>build<br>ician: To the<br>ier: On the b<br>and man | ing, etc. (Specit<br>best of my kno<br>basis of examina | <i>fy)</i><br>owledge, deat | th occurred at the<br>envestigation, in m                          | time, date and p<br>y opinion, death | Cit<br>place, and du | ty or Town, Some to the caus he time, date  | se(s) and me and place . Date signe | manner as<br>e, and due<br>ned (Month | stated.<br>to the cause(s)                     |

DHMH 17 Rev 1/2001

Laura Marie Tessieri

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 06378

|                                                                                                                                                                                                                                  |                   | I- For State<br>Registrar                                                                                               |                               |                             |                       | Cei                    | rtificate    | of i                             | Death      | 1                    |                    |              | 1                 | Reg. No.         |                          |                 |                 |           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------|-----------------------|------------------------|--------------|----------------------------------|------------|----------------------|--------------------|--------------|-------------------|------------------|--------------------------|-----------------|-----------------|-----------|
| Physicia                                                                                                                                                                                                                         |                   | 1 Decedent's Name (First, Middle,Last) 2. Date of Death                                                                 |                               |                             |                       |                        |              |                                  |            |                      |                    |              |                   |                  | 13                       | 3. Time of Deat | th              |           |
| edical Examir                                                                                                                                                                                                                    |                   | Laura Ma                                                                                                                | arie T                        | essie                       | ri                    |                        |              |                                  |            |                      |                    |              | Month<br>February | 9, 200           | 08                       |                 | 0514 hrs        |           |
|                                                                                                                                                                                                                                  |                   | 4a. Facility Name (if                                                                                                   | not institution               | on, give stre               | et and nun            | nber)                  |              | 4t                               | b. City, T | own, or L            | ocation of         |              |                   |                  | . County of              | Death           |                 |           |
|                                                                                                                                                                                                                                  |                   | SB I-97 N of                                                                                                            | Hawkins                       | Road                        |                       |                        |              |                                  | Annar      | oolis                |                    |              | Anne Arundel      |                  |                          |                 |                 |           |
| Funeral                                                                                                                                                                                                                          |                   | 5. Social Security N                                                                                                    | umber                         | 6. Sex                      |                       | 7. Age (In yrs. I      | ast birthda  | y)                               | If Unde    | r 1 Year             | If Under           | 24Hrs.       | 8. Date of E      | Birth (MM        |                          |                 | place (State or |           |
| Director                                                                                                                                                                                                                         |                   | 218-04-9                                                                                                                |                               | 1 1                         | 237 -                 |                        | 24           | Months Days Hours Min. 7/10/1092 |            |                      |                    |              |                   |                  | 3                        | Foreign<br>Cout | ntry) Mary      | land      |
|                                                                                                                                                                                                                                  |                   |                                                                                                                         |                               | 1M                          | 2 X  F                |                        | 47           | Yrs. //19/1903                   |            |                      |                    |              |                   |                  |                          |                 | y               |           |
| ž.                                                                                                                                                                                                                               | - }               | Usual Residence of<br>10a. State                                                                                        | Decedent<br>10b. County       |                             | -                     | 10c City               | . Town or L  | ocatio                           | on .       | 10d. Inside City Lim |                    |              |                   |                  |                          |                 |                 | y Limits  |
| w an                                                                                                                                                                                                                             |                   |                                                                                                                         |                               | A                           | .1.1                  | , oo. oity             |              |                                  |            |                      |                    |              | 1 Yes 2           |                  |                          |                 |                 |           |
| land<br>f sho                                                                                                                                                                                                                    | إق                | MD                                                                                                                      |                               | Arun                        | ueı                   |                        | Arno         | тa                               |            |                      |                    |              |                   | 40. 5            |                          |                 |                 | -         |
| with the Maryland<br>ns 23a or 28a-f show any<br>be notified at once                                                                                                                                                             | Director          | 10e. Street and Nur 477 Mano:                                                                                           |                               | A-> +                       | ٨                     |                        |              |                                  | 10f. Zip   | Code<br>L012         |                    |              |                   | rug. Cit         | izen of Wha              |                 | 1 <b>y</b> ?    |           |
| the la or                                                                                                                                                                                                                        |                   | 4// Mano.                                                                                                               | r Ku.                         | Apt.                        | A                     |                        |              |                                  | ۷.         | 1012                 |                    |              |                   |                  | UDA                      |                 |                 |           |
| with the ms 23a be noti                                                                                                                                                                                                          | Funeral           | 11. Marital Status                                                                                                      |                               |                             |                       | edent Ever in U        | l.S. 13      |                                  |            |                      |                    |              | cify Yes or N     | No-              | 14. Race -<br>White,     |                 | an Indian, Blac | k,        |
| r iter                                                                                                                                                                                                                           | Ĕ١                | 1 X Never Marrie                                                                                                        | ed 2 N                        | tarried 1                   | Armed Fo<br>Yes       | 2 X No                 |              | 11 16                            | s, specit  | y Cuban,             | Mexican,           | , ueito Ki   | ican, Glo.        |                  | 771116                   | , 010.          |                 |           |
| fter d                                                                                                                                                                                                                           |                   | 3 Widowed                                                                                                               | 4 Di                          | vorced If Ye                |                       |                        |              |                                  | Yes 2      | XX No                | specify:           |              |                   |                  | Specify:                 | Wł              | nite            |           |
| 21215-0036 Id be filed within 72 hours after Mental Hygiene. narked other than "natural", event, the Medical Examiner                                                                                                            | a p               | 15. Decedent's Ed                                                                                                       | lucation (Spe                 | ecify only hi               | ghest grad            | e completed)           |              |                                  |            |                      | on (Give k         |              |                   | 16b.             | Kind of Bus              | siness/In       | dustry          |           |
| 72 ho                                                                                                                                                                                                                            | Completed         | Elementary/Seco                                                                                                         | ondary (0-12)                 |                             | College (1-           | -4 or 5+)              | duri         | ng mo                            | ost of wor | king lite. I         | DO NOT (           | use retire   | u)                |                  |                          |                 |                 |           |
| thin that                                                                                                                                                                                                                        | ם                 |                                                                                                                         |                               |                             | 4                     |                        | Stu          | den                              | nt         |                      |                    |              |                   | S                | choo1                    |                 |                 |           |
| 5-0<br>3d wi<br>ygien<br>other                                                                                                                                                                                                   | 흥                 | 17. Father's Name                                                                                                       | (First, Middle                | , Last)                     | _                     |                        |              |                                  |            | 1                    | 8.Mother's         | s Name (F    | First, Middle     | , Maider         | Surname)                 |                 |                 |           |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica                                                                                                                                           | Be (              | David Te                                                                                                                | ssieri                        |                             |                       |                        |              |                                  |            |                      | Gail               | Eve          | Pizi              | e                |                          |                 |                 |           |
| D 21215-0036<br>should be filed within 72 hours after death with the Mary/and<br>and Mental Hygiene.<br>7 is marked other than "natural", or items 23a or 28a-f sh<br>natic event, the Medical Examiner must be notified at once | 2                 | 19a. Informant's Na                                                                                                     |                               |                             | Print )               |                        | 19b. N       | lailing                          | Address    | (Street              | and Num            | ber or Ru    | ral Route N       | umber, C         | City or Town             | n, State,       | Zip Code)       |           |
| imore, MD 2 Pages 1 and 2 shou ment of Health and N lant: If item 27 is n or other traumatic                                                                                                                                     |                   | David Te                                                                                                                | ssieri                        | . F                         | ather                 | :                      | 691          | 8 3                              | 34th       | Ave                  | W B                | rade         | nton,             | F1               | 342                      | 09              |                 |           |
| and and team trau                                                                                                                                                                                                                | ŀ                 | 20a. Method of Disp                                                                                                     | position                      |                             |                       |                        | Place of D   | isposi                           | tion (Nar  | ne of cem            |                    |              | Date              |                  | . Location -             | City or 7       | Town, State     |           |
| ore<br>ges 1<br>tof F<br>ther                                                                                                                                                                                                    |                   | 1 Burial 2                                                                                                              |                               |                             | Removal fro           |                        | crematory    |                                  |            |                      |                    | 2/12         | /2000             |                  | 1 4 2 :                  | ***             | MD              |           |
| fim<br>Fag<br>Innent                                                                                                                                                                                                             |                   | 4 Donation 5                                                                                                            | Other S                       | Specify:                    |                       | Me                     | tro C        |                                  |            |                      |                    |              | /2008             |                  | 1timo                    |                 |                 | -         |
| Baltimore, MC permit. Pages 1 and 2 st Department of Health ar Important: If item 27 injury or other trauma                                                                                                                      |                   | 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Hardesty Fundamental Ridgely Ave. Annapolis, |                               |                             |                       |                        |              |                                  |            |                      |                    | Fun          | eral              | Home             | e, P.A.                  |                 |                 |           |
|                                                                                                                                                                                                                                  |                   | 100                                                                                                                     | 1                             |                             |                       |                        |              |                                  |            |                      |                    |              |                   |                  |                          |                 | Approximate     | Interval  |
| Physician                                                                                                                                                                                                                        |                   | 23a. Part I. Enter the failure. List on                                                                                 | ie diseas⊌, o<br>Iy one causi | r complicat<br>e on each li | ions that ca<br>ne.   | aused the deat         | i. Do not e  | nter th                          | ie mode (  | oi ayıng, s          | SUCH as ca         | ar urac of I | espiratory        | un est, Sf       | IOUN, UI HEE             | 411             | Between On      | set and   |
| /Medical                                                                                                                                                                                                                         |                   | Immediate Cause (                                                                                                       | Final disease                 | N.A.                        | ltiple Inju           | uries                  |              |                                  |            |                      |                    |              |                   |                  |                          |                 | Deat            | II .      |
| Kammer                                                                                                                                                                                                                           |                   | or condition resulting                                                                                                  | ng in death)                  | Due                         | to (or as a           | consequence            | of):         |                                  |            |                      |                    |              |                   |                  |                          |                 |                 |           |
|                                                                                                                                                                                                                                  | إ                 | Sequentially list co                                                                                                    |                               | b                           |                       |                        | - f) .       |                                  |            |                      | _                  |              |                   |                  |                          | -               |                 |           |
|                                                                                                                                                                                                                                  | ine.              | if any, leading to in<br>cause. Enter Under                                                                             |                               |                             | to (or as a           | consequence            | ot):         |                                  |            |                      |                    |              |                   |                  |                          |                 |                 |           |
|                                                                                                                                                                                                                                  | Examiner          | (Disease or injury a                                                                                                    | nai miliateo                  | .6-                         | to (or as a           | consequence            | of):         | -                                |            | -                    |                    |              |                   |                  |                          |                 |                 |           |
| cuted<br>.nd<br>transit                                                                                                                                                                                                          |                   | Cronto resulting III                                                                                                    | Locally Last                  | d.                          |                       |                        |              |                                  |            |                      |                    |              |                   |                  |                          |                 |                 |           |
| exe exe                                                                                                                                                                                                                          | Physician/Medical | UNPENDED                                                                                                                |                               |                             | MENDED                |                        |              |                                  |            |                      |                    |              |                   |                  |                          |                 |                 |           |
| 760,<br>cate be-<br>physicia<br>the buria                                                                                                                                                                                        | Je d              | IF FEMALE:                                                                                                              |                               | 12                          | 3c If yes             | outcome of pre         | gnancy       |                                  | -          | _                    | _                  |              |                   | 2                | 3d. Date of              | delivery        | ,               |           |
| 8760, tificate by ng physic as the bur                                                                                                                                                                                           | 2                 | 23b. Was decedent                                                                                                       |                               | Ale o                       | Live b                |                        |              | Fet                              | tal death  | 3                    | Ectopic            | pregnan      | су                |                  | Month                    |                 |                 | 'ear      |
| Box 68<br>e death certi<br>the attendin<br>ed for use as                                                                                                                                                                         | cia               | past 12 months                                                                                                          |                               | 4                           |                       | ant at time of o       | leath 5      | _                                | ner (Spe   |                      |                    |              |                   | (1)              |                          |                 |                 |           |
| BOy<br>e death<br>the att                                                                                                                                                                                                        | ıys               | 1 Yes 2 1                                                                                                               | No 9 🗹 Ut                     | nknown g                    | Unkno                 | own                    |              |                                  |            |                      |                    |              |                   |                  |                          |                 |                 |           |
| O. — at the lby the taches                                                                                                                                                                                                       |                   | Part II. Other signi                                                                                                    | ificant cond                  | itions cor                  | ntributing to         | death but not          | resulting in | the u                            | ınderlying | g cause g            | jiven in Pa        | rt I.        |                   |                  |                          |                 | the cause of de |           |
| ires that the signed by the detacht                                                                                                                                                                                              | d by              |                                                                                                                         |                               |                             |                       |                        |              |                                  |            |                      |                    |              | 1                 | Yes 2            | <b>✓</b> No 3            | Prot            | ably 4 Ur       | nknown    |
| rds,<br>require<br>been si                                                                                                                                                                                                       | Completed         |                                                                                                                         |                               |                             |                       |                        |              |                                  |            |                      |                    |              | 24a. W            |                  |                          |                 | topsy findings  |           |
| law re has be                                                                                                                                                                                                                    | βqr               |                                                                                                                         |                               |                             | -                     |                        |              |                                  |            |                      |                    |              | ре                | topsy<br>rformed | ?                        | death?          | completion of c | -         |
| Records, The law requir, ficate has been s                                                                                                                                                                                       | ő                 |                                                                                                                         |                               |                             |                       |                        |              |                                  |            |                      |                    |              | 1 🗸 Ye            | s 2              | No 1                     | <b>✓</b> Ye     | es 2            | No        |
| tal Rectian: The certificate ector, page                                                                                                                                                                                         | Be C              | 25. Was case refer                                                                                                      | red to medic                  | _                           |                       |                        |              |                                  |            |                      | of Death           |              |                   |                  |                          |                 |                 |           |
| of Vital ng Physician: After this certi                                                                                                                                                                                          | To B              | examiner?<br>1 ✓ Yes                                                                                                    | 2 No                          | Hosp                        | oital: 1 1            | npatient 2             | ER/Outp      | atient                           | 3 [        | DOA                  | Other <sub>4</sub> |              | Home 5            |                  | dence 6                  |                 | r: Scene        |           |
| of<br>ing Ph<br>After t                                                                                                                                                                                                          |                   | 27. Manner of Dear                                                                                                      |                               |                             | 28a. Date<br>Feb 9, 2 | of Injury<br>Day,Year) | 28b. Tin     |                                  | njury      |                      | ry at Work         | le le        | 28d, Descri       | be how in        | njury occurr<br>fixed ob | red<br>iect co  | ollision        |           |
| ion<br>tendir<br>eath.<br>tor: A                                                                                                                                                                                                 | tio               | 1 Natural                                                                                                               |                               | nding                       | Feb 9, 2              | :008                   | 0433 h       | rs                               |            | 1 Y                  | Yes 2 ✔            | No           | acconge           | . auto           |                          | .,              |                 |           |
| Division<br>tal or Attendi<br>rs after death.<br>al Director: //                                                                                                                                                                 | fica              | 2 Accident 3 Suicide                                                                                                    |                               | estigation  <br>uld not be  | 28e. Plac             | e of Injury - At       | home, farm   | , stree                          | et, factor | y, office b          | uilding, et        |              |                   |                  |                          |                 | iral Route Num  | ber, City |
| Divis pital or At ours after d teral Direct                                                                                                                                                                                      | Certification:    | 3 Suicide Homicide                                                                                                      |                               | ermined                     | (Specify)             | Interstate             | /Expres      | 3                                |            |                      |                    | S            | SB I-97 N         | of Hawk          | kins Road,               | , Annap         | oolis, MD       |           |
| Tospi<br>4 hou<br>funer                                                                                                                                                                                                          |                   | 29a. Certifier                                                                                                          | Certifying                    | Ph sician∕                  |                       | at of my knowle        |              | _                                | red at the | e time, da           | ate and pla        | ace, and     | due to the c      | ause(s)          | and manner               | r as stat       | ed.             |           |
| Division To the Hospital or Attend within 24 hours after death To the Funeral Director:                                                                                                                                          | Medical           |                                                                                                                         | Medical Ex                    | aminer On                   | the basis             | of examination         | and/or inv   | estigat                          | tion, in m | y opinion            | , death oc         | curred at    | the time, d       | ate and p        | place, and c             | due to th       | e cause(s)      |           |
| To To                                                                                                                                                                                                                            | Mec               | 29b. Signature and                                                                                                      | title of certif               |                             | d manner s            | tated.                 |              |                                  | 29         | c. Licens            | e number           |              |                   | 290              | d. Date sign             | ned (Mo         | nth, Day, Year) |           |
| _                                                                                                                                                                                                                                | _                 |                                                                                                                         | //                            | / [                         |                       |                        |              |                                  |            | O.C.I                |                    |              |                   | Fe               | ebruary 9                | 9, 2008         | 3               |           |
|                                                                                                                                                                                                                                  |                   | /                                                                                                                       |                               |                             |                       |                        |              |                                  |            |                      |                    |              |                   |                  |                          |                 |                 |           |
| 01/000                                                                                                                                                                                                                           |                   | 30. Name and a                                                                                                          |                               |                             |                       |                        |              | 44                               | 1 5-       | Ct                   | Daltie             | ore NA       | D 24204           |                  |                          |                 |                 |           |
| OCHOCME                                                                                                                                                                                                                          |                   | Mary G. Air                                                                                                             | ople MD.                      | Deput                       | y Chief I             | Medical Exa            | aminer       | 111                              | Penn       | Street               | , Baitim           | ore, Mi      | D 21201           |                  |                          |                 |                 |           |
|                                                                                                                                                                                                                                  | tate              |                                                                                                                         | th, Day, Year                 | 2 200                       | 32. R                 | gistrar's Signa        | ture         |                                  | ast        |                      |                    |              |                   |                  |                          |                 |                 |           |
| Reais                                                                                                                                                                                                                            |                   |                                                                                                                         |                               |                             |                       |                        |              |                                  |            |                      |                    |              |                   |                  |                          |                 |                 |           |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2008 40 am Robert Eugene Tabor rebriar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virginia Social Security Number 6. Sex . Age (In yrs. last birthday, **Funeral** 1 X M 2 □ F 218-42-5867 63 **Director** July 21,1944 Usual Residence of Decedent 10c. City, Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2(XNo Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 40121 Greenmount Lane 20659 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ģ Specify. 3 ☐ Widowed 4 € Divorced White Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Forklift Operator Lumber Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Monroe Tabor Thelma Gladys 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau Betty S. Burton/Sister 7511 Amesbury Ct., Alexandria, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Brinsfield-Echols 2/16/2008 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, 21. Signature of Fune al Service Libens M00817 MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNG CANCER 4 months /Medical Due to (or as a consequence of): Examiner EMPHYSEMA 4 months Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Ves 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate has irector, page 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No thours after death.

\*Uneral Director: A
ely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Slign 0 64330 2-15-08

within 24 hours a To the Funeral C 5dl

DHMH 17 Rev 1/2001

'natural", or

marked other than

filed

Pages 1 and 2 should be Health and Mental

that the death certificate be executed

Box 68760.

Division or Vital Records, P.O.

Hospital or Attending Physician:

death.

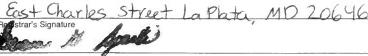
Baltimore, Maryland 21215-003

31. Date filed (Month, Day, Year) State Registrar

2008

TARIQ SHAFI MD FUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ORIGINAL

State of Maryland / Department of Health and Mental Hygien® \(\Omega\) \(\Omega\)

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|                                   |                                                                                                                                                                                                                                                                                             |                     |                                                                                                                                   |                                                                                        | Cert                               | tificate of                                                 |                                                | omai riy                         | Reg. No.         | UO U                                   | 300                    |
|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------|------------------------------------------------|----------------------------------|------------------|----------------------------------------|------------------------|
| ı                                 | Physic                                                                                                                                                                                                                                                                                      | ian                 | Decedent's Name (First, Middle, Las                                                                                               |                                                                                        |                                    |                                                             |                                                | 2. Date of De<br>Month           | eath<br>Day      |                                        | me of Death            |
|                                   | /Med                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                   | Johnson Thoma                                                                          | as                                 |                                                             |                                                | 2-                               | 8-2              | 7008 1                                 | 30am                   |
| a k                               | Exami                                                                                                                                                                                                                                                                                       | ner                 | 4a. Facility Name (If not institution, give<br>Woodside Center                                                                    |                                                                                        |                                    | 4                                                           | \$b. City, Town, or Loc<br>Silver Sp           |                                  |                  | y of Death  tgomery                    |                        |
|                                   | Funeral<br>Director                                                                                                                                                                                                                                                                         |                     | 379-34-2013                                                                                                                       | 7. Age (In yrs. I                                                                      | last birthday)<br>Yrs.             | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.                 | 8. Date of Bir<br>(Month, Da     |                  | 9. Birthplace (S                       |                        |
|                                   | and                                                                                                                                                                                                                                                                                         |                     | Usual Residence of Decedent  10a. State 10b. County                                                                               | 10c. City                                                                              | y, Town or Loca                    | ation                                                       |                                                |                                  |                  | 10d Inc                                | de City Limits         |
|                                   | Maryl<br>f sho                                                                                                                                                                                                                                                                              | ğ                   | Maryland Montgom                                                                                                                  |                                                                                        |                                    | Spring                                                      |                                                |                                  |                  | ,                                      | Yes 2 No               |
|                                   | 1 the                                                                                                                                                                                                                                                                                       | rec                 | 10e. Street and Number                                                                                                            |                                                                                        | DIIVOI                             | 10f. Zip Code                                               |                                                | 1                                | 10g. Citizen of  | What Country?                          |                        |
|                                   | h with                                                                                                                                                                                                                                                                                      | <u></u>             | 9101 Second Str                                                                                                                   | eet                                                                                    |                                    | 20910                                                       | )                                              |                                  |                  | States                                 |                        |
| 20                                | be filed within 72 hours after death with the Maryland ntal Hygiene.  Id other than "natural; or items 23a or 28a-f show event, the Madical Examiner must be invitiled at                                                                                                                   | by Funeral Director | 11. Marital Status  1 □ Never Married 2 □ Married                                                                                 | 12. Was Decedent Ever in U,<br>Armed Forces?<br>1 ☐ Yes 2 █ No<br>If Yes, Give         | lf `                               |                                                             | ispanic Origin? (Spe<br>ın, Mexican, Puerto F  | cify Yes or No<br>Rican, etc.)   | 14. Rad<br>Bla   | ce - American India<br>ck, White, etc. | an,                    |
| Maryland 21215-0020               | hour:                                                                                                                                                                                                                                                                                       | D<br>D              | 3 X Widowed 4 □ Divorced                                                                                                          | Year or Dates:                                                                         |                                    |                                                             |                                                |                                  |                  |                                        |                        |
| 15                                | in 72<br>"nat                                                                                                                                                                                                                                                                               | Completed           | 15. Decedent's Edu<br>(Specify only highest grad                                                                                  | le completed)                                                                          | 16a. Decede<br>(Give ki            | nt's Usual Occupi<br>ind of work done of<br>NOT use retired | ation<br>du <i>ring most of workin</i><br>f)   | g                                |                  | usiness/Industry                       |                        |
| 712                               | with<br>ene.<br>than                                                                                                                                                                                                                                                                        | E E                 | Flementary/Secondary (0-12) <b>7th grade</b>                                                                                      | College (1-4or 5+)                                                                     |                                    | Services                                                    | ,                                              |                                  |                  | stration                               | -5                     |
| Ö                                 | e filed within<br>al Hygiene.<br>I other than '<br>vent, the Ma                                                                                                                                                                                                                             |                     | 17. Father's Name (First, Middle, Last)                                                                                           |                                                                                        |                                    |                                                             | 18. Mother's Name                              | (First, Middle                   |                  |                                        |                        |
| <u>la</u>                         | should be find Mental Firmarked of                                                                                                                                                                                                                                                          | To Be               | Charlie Archie                                                                                                                    | Johnson                                                                                |                                    |                                                             | Mollie                                         | Tray                             |                  | ,                                      |                        |
| ary                               | shou<br>ind M<br>imar<br>umat                                                                                                                                                                                                                                                               | -                   | 19a. Informant's Name/Relationship (T)                                                                                            |                                                                                        | 19b. Mailing                       | Address (Street a                                           | and Number or Rural                            |                                  |                  | State, Zip Code)                       | 10141                  |
| Σ                                 | alth a                                                                                                                                                                                                                                                                                      |                     | Ernest Odell Will                                                                                                                 | iams (Son)                                                                             |                                    |                                                             | nus Stree                                      |                                  |                  |                                        |                        |
| ore,                              | permit. Pages 1 end 2 should b<br>Department of Health and Ments<br>important: if item 27 is marked<br>any injury or other traumatic en<br>once.                                                                                                                                            |                     | 20a. Method of Disposition                                                                                                        |                                                                                        | ace of Disposit                    |                                                             |                                                | Date                             | 20c. Location -  | City or Town, Sta                      |                        |
| Ĕ                                 | Page<br>nent of<br>nr: if                                                                                                                                                                                                                                                                   |                     | 1 Burial 2 □ Cremation 3 □ F<br>4 □ Donation 5 □ Other (Specify)                                                                  | ternoval from State                                                                    | -                                  |                                                             | " Fe<br>Cemetery                               | b.16,2                           | 2008             | nd, Mary                               | land                   |
| altimore,                         | permit. Departrimporta any inju                                                                                                                                                                                                                                                             |                     | 21. Signature of Funeral Service Liceris                                                                                          |                                                                                        | 22.1                               | Name and Addres                                             | s of Facility                                  |                                  |                  |                                        | Land                   |
| Ω                                 | 89 1 8 8                                                                                                                                                                                                                                                                                    |                     | Acceptable to                                                                                                                     | 211                                                                                    | 60                                 | N. Hor                                                      | ton Compa<br>y Street,                         | ny Mor                           | ticians,         | Inc.                                   | 20011                  |
|                                   |                                                                                                                                                                                                                                                                                             |                     | 23a. Part1. Enter the disease, or compl<br>shock, or heart failure. List only or                                                  | ications that caused the death                                                         | . Do not enter                     | the mode of dying                                           | g, such as cardiac or                          | respiratory a                    | rest,            | Approx                                 | imate                  |
| æ                                 | Physician                                                                                                                                                                                                                                                                                   |                     | Shock, or neart failure. List only of                                                                                             | ne cause on each line.                                                                 |                                    |                                                             |                                                |                                  |                  | Interva<br>Onset                       | l Between<br>and Death |
| į.                                | /Medical                                                                                                                                                                                                                                                                                    |                     | Immediate Cause (Final disease or condition                                                                                       | Advance                                                                                | Day                                | a.tis                                                       |                                                |                                  |                  |                                        |                        |
| П                                 | Examiner                                                                                                                                                                                                                                                                                    |                     | resulting in death)                                                                                                               |                                                                                        | as a conseque                      |                                                             |                                                |                                  |                  |                                        |                        |
| -                                 | ס ≠                                                                                                                                                                                                                                                                                         | ner                 | Section 1                                                                                                                         |                                                                                        |                                    |                                                             |                                                |                                  |                  |                                        |                        |
|                                   | acute<br>ind<br>trans                                                                                                                                                                                                                                                                       | E E                 | Sequentially list conditions,                                                                                                     | Due to (or                                                                             | as a culliseque                    | ກາດອຸ້ນຖື.                                                  |                                                |                                  |                  |                                        |                        |
| ,<br>0                            | oe exe                                                                                                                                                                                                                                                                                      | <u> </u>            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |                                                                                        |                                    |                                                             |                                                |                                  |                  |                                        |                        |
| x 68760,                          | ertificate be executed<br>ling physician and<br>se as the buriel-transit                                                                                                                                                                                                                    | Medical Examiner    | that initiated events resulting in death) Last                                                                                    | Due to (or                                                                             | as a conseque                      | nce of):                                                    |                                                |                                  |                  |                                        |                        |
| ×                                 | ires thet the death certificate be executed signed by the attending physician and be detached for use as the buriel-transit                                                                                                                                                                 | Me                  | L a                                                                                                                               | l,                                                                                     |                                    |                                                             |                                                |                                  |                  |                                        |                        |
| 8                                 | atten<br>for u                                                                                                                                                                                                                                                                              | Physician.          |                                                                                                                                   |                                                                                        |                                    |                                                             |                                                |                                  |                  | 1                                      |                        |
| o                                 | the de                                                                                                                                                                                                                                                                                      | ysi                 | Part II. Other significant conditions con                                                                                         | tributing to death but not resul                                                       | ting in the unde                   | erlying cause give                                          | en in Part I.                                  | 23b. Did t                       | obacco use co    | ntribute to the ca                     | use of death?          |
| <b>J</b>                          | thet the deta                                                                                                                                                                                                                                                                               |                     | HTN                                                                                                                               |                                                                                        |                                    |                                                             |                                                | 101                              | res 2□ No        | 3 Probably                             | 1 Unknown              |
| g                                 | uires<br>sigr<br>lid be                                                                                                                                                                                                                                                                     | d by                | N 110                                                                                                                             |                                                                                        |                                    |                                                             |                                                | 24a Was                          | an autopsy       | 24b. Were auto                         | nsv findings           |
| <del>ဂ</del>                      | v require<br>been si<br>should                                                                                                                                                                                                                                                              | Completed           | DM                                                                                                                                |                                                                                        |                                    |                                                             |                                                | perfo                            | rmed?            | available p                            | rior to                |
| Ä                                 | ne fav<br>e has<br>ige 2                                                                                                                                                                                                                                                                    | Ĕ                   |                                                                                                                                   |                                                                                        |                                    |                                                             |                                                |                                  | -/               | of death?                              | _                      |
| Division of Vital Records, P.O. B | nysician: The law<br>his certificate has b<br>I director, page 2 s                                                                                                                                                                                                                          |                     | 25. Was case referred to medical                                                                                                  |                                                                                        |                                    |                                                             | 00 81- 17                                      | 1 T                              |                  | 1 ☐ Yes                                | 2∐ No                  |
| 5                                 | s cert<br>direct                                                                                                                                                                                                                                                                            | To Be               | examiner?                                                                                                                         | ospital:<br>1 ☐ Inpatient 2 ☐ E                                                        | P/Outpationt                       | 2C DOA Othe                                                 | 26. Place of Death                             |                                  |                  | (0it-)                                 |                        |
| Ö                                 | y Phy<br>er thi                                                                                                                                                                                                                                                                             |                     | 27. Manner of Death                                                                                                               | 28a. Date of Injury                                                                    | 28b. Time of                       | 28c. Injury<br>Work                                         | at 28                                          |                                  | ow injury occurr |                                        |                        |
| 0                                 | Attending Phore of death.  ector: After this by the funeral                                                                                                                                                                                                                                 | atio                | 1.☑Natural 5 ☐ Pending<br>2 ☐ Accident investigation                                                                              | (Month, Day Year)                                                                      | Injury                             |                                                             | ?<br>′es 2 □ No                                |                                  |                  |                                        |                        |
| <u> </u>                          | Atte<br>er de<br>by th                                                                                                                                                                                                                                                                      | E                   | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined                                                                           | 28e. Place of Injury - At hom<br>building, etc. (Specify)                              | ne, farm, street                   | , factory, office                                           | 28                                             |                                  |                  | er or Rural Route                      | Number,                |
| 5                                 | taior<br>rsaft<br>al Dir<br>ed in                                                                                                                                                                                                                                                           | CertIfication:      | 4 E Homodo                                                                                                                        | building, etc. (Specify)                                                               |                                    |                                                             |                                                | City or Tow                      | n, State)        |                                        |                        |
|                                   | To the Hospital or Attending Physician: The law requires that the death or within 24 hours after death the state of the state of the strength Director. After this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for us | edicai              | 29a. Certifier (Check only one) 1                                                                                                 | ician: To the best of my knowl<br>er: On the basis of examinatio<br>and manner stated. | ledge, death oc<br>on and/or inves | ccurred at the time<br>tigation, in my opi                  | e, date and place, an<br>inion, death occurred | d due to the d<br>at the time, d | ause(s) and ma   | nner as stated.<br>and due to the cau  | se(s)                  |
|                                   | Neith Control                                                                                                                                                                                                                                                                               | Σ                   | 29b. Signature and title of certifier                                                                                             | *                                                                                      |                                    | 29c. License                                                | number                                         | 2                                |                  | Month, Day, Yea                        | ar)                    |
|                                   |                                                                                                                                                                                                                                                                                             |                     | J. agraal                                                                                                                         |                                                                                        |                                    | D006                                                        | 55301                                          |                                  | 02/08            | 108.                                   |                        |
| 9                                 |                                                                                                                                                                                                                                                                                             |                     | 30. Name and address of person who cor                                                                                            |                                                                                        |                                    | •                                                           |                                                |                                  | / /              |                                        |                        |
|                                   |                                                                                                                                                                                                                                                                                             |                     | Farzana Ajmal, M.I                                                                                                                |                                                                                        |                                    |                                                             | r Spring,                                      | Maryla                           | ind 2091         | .0                                     |                        |
|                                   | Sta<br>Registra                                                                                                                                                                                                                                                                             |                     | 31. Date filed (Month, Day, Year) FEB 1 4 2008                                                                                    | 32. Registrar's Signatu                                                                | light)                             | D44                                                         |                                                |                                  |                  |                                        |                        |
|                                   | Liegioti                                                                                                                                                                                                                                                                                    |                     | 1.60 = 3                                                                                                                          | WHEN IN I                                                                              |                                    |                                                             |                                                |                                  |                  |                                        |                        |

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sician and burial-trans Division or Vital Records, P.O. Box 68760. attending physician for use as the buria within 24 hours at To the Funeral D completely filled i

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Paul Robert Vinansky 2/11/2008 8:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 76 082-24-3117 7/9/1931 Taylor, PA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be not principle. 20715 U.S.A. 3705 Irongate Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: -1972Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service 12 Mail Handler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Vinansky Anna Holodnak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3705 Irongate Ln., Bowie, MD 20715 Denise V. Lattanzi, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 3/4/2008 Arlington, VA 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 30 Mins disease or condition resulting in death) Acute Myocardial Infarction /Medical Due to (or as a consequence of): **Examiner** Coronary Artery Disease 7 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Obstructive Pulmonary Disease 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 1 ☐ Yes 2 ☒ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D26287 February 12, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Berard 7505 Baltimore Blvd., College Park, MD 20740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 4 2008 Registrar

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Division or Vital Records, P.O. Box 68760,

| State of Maryland / Department of Health and Mental Hygie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | nie                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| Reg.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | No.2008 05382                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Day Year                                                                    |
| Medical Saundra D. Smith Whitaker Februar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | y 21,2008 11:10Å<br>4c. County of Death                                     |
| Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | •                                                                           |
| 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Prince Georges  9. Birthplace (State or Foreign                             |
| Funeral Director  241-15-3406  Director  241-15-3406  Director  241-15-3406                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ear) Country)                                                               |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                             |
| 10a. State 10b. County 10c. City, Town or Location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 10d. Inside City Limits                                                     |
| The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | 1 ⊈Yes 2 No                                                                 |
| Md. PG Cheltenham  10e. Street and Number  10f. Zlp Code  10f. Zlp Code  10g.  10g.  10g.  10g. Street and Number  10f. Zlp Code  10g.  10g.  10g.  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  10 | . Citizen of What Country?                                                  |
| ្នុំ នូម <u>ទ</u> 10500 Furling Court 20623 ប្                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Jnited States                                                               |
| 12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)  14. Marital Status  15. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <ol> <li>Race - American Indian,<br/>Black, White, etc.</li> </ol>          |
| 9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Specify: Black                                                              |
| To a. State 10b. County 10c. City, Town or Location  Md. PG Cheltenham  10c. Street and Number 10f. Zip Code 10g.  10g. Street and Number 10f. Zip Code 10g.  10g. Street and Number 10f. Zip Code 11g. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never or Dates:  1 Never Married 2 Married 1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1 Never Married 2 Never Or Dates:  1  | b. Kind of Business/Industry                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                             |
| College (1-4or 5+)   College (1-4or 5+)   Elementary/Secondary (0-12)   College (1-4or 5+)   Account Specialist     To provide the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second se   | Government                                                                  |
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| Charles Smith Bertha M. Howa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | rd                                                                          |
| 10a. State   10b. County   10c. City, Town or Location   10c. City Town or Location   10c. City, Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Locati   | ity or Town, State, Zip Code)                                               |
| Jordan Whitaker/husband Cheltenham, Md. 20623                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                             |
| 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | c. Location - City or Town, State                                           |
| 4 Donation 5 Other (Specify) Washington Nat. Cem. 2/28/07                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Suitland, Md.                                                               |
| Elementary/Secondary (0-12)  College (1-4or 5+)  ACCOUNT Specialist  17. Father's Name (First, Middle, Last)  Charles Smith  19a. Informant's Name/Relationship (Type. Print)  Jordan Whitaker/husband  College (1-4or 5+)  ACCOUNT Specialist  18. Mother's Name (First, Middle, Main Bertha M. Howa Charles Smith  19b. Mailing Address (Street and Number or Rural Route Number, College of Disposition (Name of Cheltenham, Md. 20623)  20a. Method of Disposition    Seurial 2   Cremation 3   Removal from State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                             |
| STORY NAME OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE  |                                                                             |
| 23a. Part Inter the disease, or complications to a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Interval Between Onset and Death                                            |
| Physician Immediate Cause (Final disease or condition resulting in death)  Medical Immediate Cause (Final disease or condition nesulting in death)  Physician Immediate Cause (Final disease or condition nesulting in death)  a. Septicemia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                             |
| Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                             |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)  Sequentially list conditions, if any, leading to immediate cause inter Underlying Cause (Disease or Injury)  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                             |
| Due to (or as a consequence of):    Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                             |
| that initiated events resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last resulting in death) Last |                                                                             |
| Cause (Disease or injury that initiated events resulting in death) Last    Cause (Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                             |
| W IF FEMALE:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                             |
| IF FEMALE:  23c. If yes, outcome pf pregnancy  1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 23d. Date of delivery  Month Day Year                                       |
| Unknown    In the past 12 monsts   4 Pregnant at time of death   5 Other (specify)   9 Unknown   9 Un  | World Day Foat                                                              |
| FFEMALE: 23b. Was decedent pregnant in the past 12 mop fis? 1   Yes 2 1   Yes   Yes, outcome pf pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   5   Other (specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | cco use contribute to the cause of death?                                   |
| y B Renal Transplantation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                             |
| Renal Transplantation  1   Yes   2   2   3   4   4   4   4   4   4   4   4   4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                             |
| 24a. Was an autopsy performer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 24b. Were autopsy findings available prior to completion of cause of death? |
| T in the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of  | PNo 1 ☐ Yes 2 PNo                                                           |
| 25. Was case referred to medical examiner?  1   Yes   2   End of Death   26. Place of Death   26. Place of Death   26. Place of Death   26. Place of Death   26. Place of Death   26. Place of Death   26. Place of Death   26. Place of Death   26. Place of Death   26. Place of Death   27. Manner of Death   28a. Date of Injury   28b. Time of   28c. Injury at   28d. Describe how                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                             |
| To serice: 1 Department 2 ER/Outpatient 3 DOA Under: 4 Nursing Home 5 Residence 1 Properties: 1 Department 2 Sec. Injury at 28d. Describe how                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                             |
| 27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  1 Natural 5 Pending (Month, Day Year)  28d. Describe how Injury  M 1 Yes 2 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                             |
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| 5 5 2 5 E   L   Tolling, do. (c) costly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | State)                                                                      |
| 29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                             |
| 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause o | e and place, and due to the cause(s)                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Date signed (Month, Day, Year)                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2/26/08                                                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Edear V FO Har Driver 1328 Southern true SE wash. De                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | . 20022                                                                     |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                             |
| Edger U Fo Her Shall 1328 Southern Fre St. Coash. No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 3                                                                           |
| State Registrar  31. Date (illed (Month, Day, Year)  32. Registrar's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 3                                                                           |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Laj Wanti February 08 2008 01:35 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 51 South Down Road Edgewater 8. Date of Birth (Month, Day, Year) 02/15/1920 9. Birthplace (State or Foreign Country)
India If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛣 F 579-27-7988 87 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Directo Maryland | Anne Arundel Edgewater 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21037 51 South Down Road India Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📈 No Baltimore, Maryland 21215-0036 Specify Specify: Asian Indían ò 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Siri Ram Laxmi Devi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Moti La1/Son 51 South Down Road, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 02/11/2008 | Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat A rice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 4111 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A12h eime Dementia Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical Examiner ending physician and use as the burial-tran Due to (or as a consequence of): attending p signed by the a d be detached for

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, s after death.

I Director: After this
of in by the funeral d within 24 hours aft

To the Funeral D

completely filled in

| IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnan 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | 23d. Date of delivery  Month Day Year |                                                                                                                                            |  |  |  |  |  |  |
|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|
| Part II. Other significant conditions                                                   | 23e. Did tobacco use contribute to the cause of death?  1  Yes 2 3 Probably 4 Unknown                                                              |                                       |                                                                                                                                            |  |  |  |  |  |  |
|                                                                                         |                                                                                                                                                    |                                       | 24a. Was an autopsy performed?  1□ Yes 2 □ No   24b. Were autopsy findings available prior to completion of cause of death?  1□ Yes 2 □ No |  |  |  |  |  |  |
| 25. Was case referred to medical                                                        | 26. Place of Death Check onl one                                                                                                                   |                                       |                                                                                                                                            |  |  |  |  |  |  |
| examiner?<br>1 ☐ Yes 2 ☐ No                                                             | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA                                                                                                  | her: 4 Nursing Home                   | 5 ■ Residence 6 □ Other (Specify)                                                                                                          |  |  |  |  |  |  |
| 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation                       | 011                                                                                                                                                | rry at rrk? 28d.<br>Yes 2 □ No        | Describe how injury occurred                                                                                                               |  |  |  |  |  |  |
| 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine                                     |                                                                                                                                                    | 28f. I                                | Location (Street and Number or Rural Route Number,<br>City or Town, State)                                                                 |  |  |  |  |  |  |
| 29a Certifier 1 Certifying                                                              | Physician: To the best of my knowledge, death occurred at the                                                                                      | ime, date and place, and              | due to the cause(s) and manner as stated.                                                                                                  |  |  |  |  |  |  |

State

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

leted cause of death (Item 23a) (Type, Print)

SALVADOR 31. Date filed (Month, Day, Year) FFB 1

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18, 2008 Month February **Physician** William Douglas Wathen, Sr. 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1⊠M 2□F 83 Months Hours 212-34-9896 Director Maryland October 20,1924 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits or 28a-f show notified at 1 ☐ Yes 2 No Maryland St. Mary's Mechanicsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 27870 Wathen Lane 20659 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or iter 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify: Completed by 3 Widowed 4 Divorced ear or Dates: 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Tobacco Farmer 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Catherine Harding William Ford Wathen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27870 Wathen Lane Mechanicsville, MD 20659 Joan Marie Wathen / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any Injury or ot February 21. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Morganza, Maryland St. Joseph's Cemetery 2008 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 50 disease or condition resulting in death) /Medical Examiner enmon Sequentially list conditions, Due to for as a consequence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Alzhiemus 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed 2 No 1☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) Injury Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Medical Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D60888

1200

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

33. Registr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Rakhi Krishnan, M.D.

Leonardtown, MD 20650

|                                                                                                                                                                                        |                  | _                                                                       | State of Marylan                                        | d / Departme                                      | ent of Hea                                          | Ith and M              | ental Hyg                | giene               |                                         |                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------|-----------------------------------------------------|------------------------|--------------------------|---------------------|-----------------------------------------|-----------------------|
|                                                                                                                                                                                        |                  | 1 - For State Registrar                                                 | ,                                                       |                                                   | ate of De                                           |                        |                          | Reg. No. 20         | 38 06                                   | 385                   |
|                                                                                                                                                                                        |                  | 1. Decedent's Name (First, Middle, La                                   | ast)                                                    |                                                   |                                                     |                        | 2. Date of Dea<br>Month  |                     | 3. Time of                              | f Death               |
| Physic /Med                                                                                                                                                                            |                  | Bernard G                                                               | uy Willia                                               |                                                   |                                                     |                        | Februar                  | y 21, 20            | 08 2:45                                 | a.m.                  |
| Exam                                                                                                                                                                                   |                  | 4a. Facility Name (If not institution, gi                               | ve street and number)                                   | 4b. Ci                                            | ty, Town, or Loc                                    | ation of Death         |                          | 4c. County of       | Death                                   |                       |
| <u> </u>                                                                                                                                                                               | 4 2              | 28935 Point Loo 5. Social Security Number 6.                            | kout Road Sex 7. Age (In yrs.                           | last hirthday) If Und                             |                                                     | ville<br>Under 24 Hrs. | 8. Date of Birth         | St. M               | ary s<br>9. Birthplace <i>(Stat</i> e o | or Foreian            |
| Funera<br>Directo                                                                                                                                                                      |                  |                                                                         | 1M 2□F 7. Age (111 y/s.                                 | Yrs. Month                                        |                                                     | ours Min.              | (Month, Day 07/07/1      | , Year)             | Country)                                | si i oroigii          |
| 4                                                                                                                                                                                      |                  | Usual Residence of Decedent                                             |                                                         |                                                   |                                                     |                        | 0//0//1                  | . 71 7 11           |                                         |                       |
| anylan<br>show<br>d at                                                                                                                                                                 | _                | 10a. State 10b. County                                                  | 10c. Cit                                                | ty, Town or Location                              |                                                     |                        |                          |                     | 10d. Inside C                           | aty Limits<br>2. I No |
| he Ma<br>28a-f                                                                                                                                                                         | Director         | Maryland St. Mary                                                       | 's Lov                                                  | eville                                            | Zip Code                                            |                        |                          | 10g. Citizen of Wh  |                                         |                       |
| of<br>after death with the Maryland<br>or items 23a or 28a-f show<br>miner must be notified at                                                                                         |                  |                                                                         | 1 n1                                                    |                                                   | 20656                                               |                        |                          | United S            |                                         |                       |
| death<br>ms 23                                                                                                                                                                         | Funeral          | 28935 Point Loc                                                         | 12. Was Decedent Ever in U                              |                                                   | cedent of Hispa<br>pecify Cuban, M                  | nic Origin? (Spe       | ecify Yes or No-         |                     | - American Indian,                      |                       |
| after or ite                                                                                                                                                                           |                  | 1 ☐ Never Married 2 ☐ Married                                           | Armed Forces?<br>1 X Yes 2 ☐ No<br>If Yes, Give         |                                                   |                                                     | pecify:                | nicari, etc.)            | Specify:            | , White, etc.                           |                       |
| 5-UU30<br>72 hours af<br>'natural', or<br>dical Exa <u>mi</u>                                                                                                                          | d by             | 3 X Widowed 4 ☐ Divorced                                                | Year or Dates:                                          |                                                   |                                                     |                        | -                        | 16b. Kind of Bus    | White                                   |                       |
| "nati                                                                                                                                                                                  | Completed        | 15. Decedent's E<br>(Specify only highest g                             | rade completed)                                         | 16a. Decedent's U<br>(Give kind of<br>life. DO NO | sual Occupation<br>work done durin<br>Fuse retired) | ı<br>ıg most of workii | ng                       | 16b. Kind of Bus    | iness/industry                          |                       |
| d Z1Z1<br>filed within<br>Hygiene.<br>ther than "                                                                                                                                      | l duo            | Elementary/Secondary (0-12) 7                                           | College (1-4or 5+)                                      | Maintenar                                         |                                                     |                        |                          | U.S. Gov            | vernment                                |                       |
| ING 21213-UU30 be filed within 72 hours after death with the Marylan ital Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Be C             | 17. Father's Name (First, Middle, Las                                   | st)                                                     | · · · · · · · · · · · · · · · · · · ·             | 18.                                                 | Mother's Name          | (First, Middle,          | Maiden Surname      | )                                       |                       |
|                                                                                                                                                                                        | 면<br>면           | John Chunn Willia                                                       | ıms                                                     |                                                   | Ac                                                  | la Mae I               | rury                     |                     |                                         |                       |
| IIIIMOFE, IMARYIA Int. Pages 1 and 2 should artment of Health and Men ortant: If item 27 is marke injury or other traumatte.                                                           | li.              | 19a. Informant's Name/Relationship                                      | (Type. Print)                                           | 19b. Mailing Addr                                 | ,                                                   |                        |                          | er, City or Town, S | tate, Zip Code)                         |                       |
| 9, R                                                                                                                                                                                   |                  | Raymond C. Willia 20a. Method of Disposition                            |                                                         | P.O. Box                                          |                                                     |                        | e, MD 2                  | 20656               | City or Town, State                     |                       |
| Saltimore, bernit. Pages 1 a Department of Her mportant: If item                                                                                                                       |                  | 1 X Burial 2 ☐ Cremation 3                                              | ☐Removal from State                                     | cemetery, crematory (                             | or other place)                                     |                        |                          |                     |                                         |                       |
| ITIMO iit. Page artment cortant: If injury or                                                                                                                                          | al al            | 4 □ Donation 5 □ Other (Spec                                            |                                                         | arles Memo                                        | rial Ce                                             | m   UZ/Z.<br>Facility_ | 5/2008                   | Leonardt            | own, MD                                 | _ =                   |
| permit. Depart Import                                                                                                                                                                  |                  | Collected                                                               | 10//                                                    | 00052 2295                                        | 5 Hollys                                            | Brir<br>Road Roa       | nsfield<br>ad Leon       | Funeral             | Home, P.A.                              | A.<br>50              |
| 100                                                                                                                                                                                    |                  | 23a. Part1. Enter the disease, or conshock, or heart failure. List only | mplications that caused the dear                        |                                                   |                                                     |                        |                          |                     | Approxima<br>Interval Be                |                       |
| Physician                                                                                                                                                                              |                  | Immediate Cause (Final disease or condition                             | Car                                                     | namin                                             | rolot                                               | Û                      |                          |                     | Quiset and                              | 2 Day                 |
| /Medica                                                                                                                                                                                |                  | resulting in death)                                                     | Due to (or pa con                                       | quence of):                                       | nalot                                               |                        |                          |                     | 7.77                                    | rothy.                |
| Examine                                                                                                                                                                                |                  | Sequentially list conditions,                                           | b. Cot                                                  | on Ca                                             | nas                                                 | 12                     |                          |                     | 452                                     |                       |
| ted sit                                                                                                                                                                                | Examiner         | cause. Enter Underlying Cause (Disease or injury                        | Date to for see a societies                             | (desce us)                                        |                                                     |                        |                          |                     | 10                                      |                       |
| <b>60,</b> be executed ician and burlal-transit                                                                                                                                        | Exar             | that initiated events<br>resulting in death) Last                       | Due to (or as a consec                                  | quence of):                                       |                                                     |                        |                          |                     |                                         |                       |
| 0 5 0                                                                                                                                                                                  | cal              |                                                                         | d                                                       |                                                   |                                                     |                        |                          |                     |                                         |                       |
| Box 68 leath certificat attending phy for use as th                                                                                                                                    | /ledi            | IF FEMALE:                                                              | 1.7                                                     |                                                   |                                                     |                        | -                        |                     |                                         |                       |
| .C. Box 68 the death certifica y the attending ph ched for use as the                                                                                                                  | lan/             | 23b. Was decedent pregnant in the past 12 months?                       | 23c. If yes, outcome pf pregn<br>1 ☐ Live birth 2 ☐ Fet | al death 3 □Ectopi                                | c pregnancy                                         |                        |                          | 23d. Date<br>Mon    | of delivery<br>oth Day                  | Year                  |
| at the dea                                                                                                                                                                             | ysic             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                                           | 4□Pregnant at time of<br>9□Unknown                      | death 5□Other                                     | (specify)                                           |                        |                          | :                   | -                                       |                       |
| that the ed by detac                                                                                                                                                                   | by Physician/Med | Part II. Other significant conditions                                   | contributing to death but not re-                       | sulting in the underlyin                          | ng cause given in                                   | n Part I.              | 23e. Did to              | obacco use contri   | bute to the cause of                    | death?                |
| The law requires that the has been signed boage 2 should be deta                                                                                                                       |                  |                                                                         |                                                         |                                                   |                                                     |                        | 1 🗆 `                    | Yes 200No           | 3 ☐ Probabiy 4 ☐                        | ]Unknown              |
| aw rec                                                                                                                                                                                 | Completed        |                                                                         |                                                         |                                                   |                                                     |                        | 24a. Was                 |                     | Vere autopsy findings                   | s available           |
| The law                                                                                                                                                                                | mo               |                                                                         |                                                         |                                                   |                                                     |                        | autor<br>perfo<br>1⊟ Yes | rmed? de            | eath?                                   | cause of              |
|                                                                                                                                                                                        | Be C             | 25. Was case referred to medical examiner?                              |                                                         |                                                   |                                                     | S. Place of Death      |                          |                     |                                         |                       |
| Or V<br>Physic<br>this ce                                                                                                                                                              | P                | 1 Yes 2 No                                                              |                                                         | □ER/Outpatient 3□                                 |                                                     |                        |                          | dence 6 □Othe       |                                         |                       |
| DIVISION OF<br>or Attending Phy<br>after death.<br>I Director: After this<br>d in by the funeral d                                                                                     |                  | 27. Manner of Death  1. Natural 5 ☐ Pending                             | 28a. Date of Injury<br>(Month, Day Year)                | 28b. Time of<br>Injury<br>M                       | 28c. Injury at<br>Work?                             | 2 No                   | 28d. Describe I          | how injury occurre  | ıd                                      |                       |
| DIVISIO<br>I or Attend<br>after death<br>Director: /                                                                                                                                   | icati            | 2 Accident investigati                                                  | be   280 Place of injury - At h                         |                                                   |                                                     |                        | 28f. Location (          | Street and Numbe    | er or Rural Route Nu                    | mber,                 |
| lor A after Directory                                                                                                                                                                  | Certification:   | 4 ☐ Homicide determine                                                  | building, etc. (Spec                                    | ify)                                              | ,,                                                  |                        | City or Tou              |                     |                                         |                       |
| DIVISION OF VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,     |                  | 29a. Certifier 1 Certifying                                             | Physician: To the best of my kn                         |                                                   |                                                     |                        |                          |                     |                                         | u(e)                  |
| he Ho<br>in 24<br>he Fu                                                                                                                                                                | Medical          | (Check only 2 Medical Ex                                                | aminer: On the basis of examin<br>and manner stated.    | nation and/or investiga                           |                                                     |                        | red at the time,         |                     |                                         |                       |
| To t<br>To t                                                                                                                                                                           | Σ                | 29b. Signature and title of certifier                                   | 911                                                     | - 110                                             | 29c. License nu                                     | Imber                  | 9.                       |                     | (Month, Day, Year)<br>21-08             |                       |
|                                                                                                                                                                                        |                  | pa pa                                                                   | may poro                                                | E/41                                              | U                                                   | 0071                   |                          | 5                   | ×1-0                                    | ,                     |
| 3/10                                                                                                                                                                                   |                  | 30. Name and address of person what James P. Janboe                     | //                                                      | Three Note                                        | h Road                                              | Hollywa                | ood MD                   | 20636               |                                         |                       |
| / /I/V                                                                                                                                                                                 | State            | 31. Date filed (Month, Day, Year)                                       | 32 egistrar's Sigr                                      |                                                   | n Roady                                             | 11011yW                | cou, iii                 | 20000               |                                         |                       |
| Begi                                                                                                                                                                                   |                  | EED 2/2                                                                 | 2008                                                    | The American                                      | 1                                                   |                        |                          |                     |                                         |                       |

State Registrar

31. Date filed (Month, Day, Year)
FER 14 2008

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

4467 Old Branch Avenue; ste #203 Temple Hills, MD

| riease | ype of Print in Black indenble link. Elisare All Copies Are Leg |
|--------|-----------------------------------------------------------------|
|        | State of Maryland / Department of Health and Mental Hygiene     |

|             |                                                                                                                                                                                                                                                                                                                              |                | 1- For State Certific Registrar                                                                                       | cate of Death                                                                                      | Reg. I                     | No. 2000 0638                                          |  |  |  |
|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|--|--|--|
|             | Physicia                                                                                                                                                                                                                                                                                                                     | an/            | Decedent's Name (First, Middle, Last)                                                                                 |                                                                                                    | Date of Death     Month Da | 3. Time of Death                                       |  |  |  |
| Med<br>N. > | lical Exami                                                                                                                                                                                                                                                                                                                  |                |                                                                                                                       | T 0: 7                                                                                             | February 18,               | 2008 2203 NTS<br>4c. County of Death                   |  |  |  |
| •           |                                                                                                                                                                                                                                                                                                                              |                | Fracility Name (if not institution, give street and number)     Prince Georges Hospital Center                        | 4b. City, Town, or Location of Death Cheverly                                                      | 1                          | Prince George's                                        |  |  |  |
|             | Funeral                                                                                                                                                                                                                                                                                                                      |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last bi                                                              |                                                                                                    | 8. Date of Birth (N        | MM/DD/YYYY) 9. Birthplace (State or                    |  |  |  |
|             | Director                                                                                                                                                                                                                                                                                                                     |                | 213-57-2505 1XM 2DF 8                                                                                                 | Yrs, Months Days Hours Min                                                                         | Nov. 10                    | Foreign Maryland                                       |  |  |  |
|             |                                                                                                                                                                                                                                                                                                                              | H              | Usual Residence of Decedent                                                                                           | 110.                                                                                               | NOV. 1U                    | . 1999                                                 |  |  |  |
|             | any                                                                                                                                                                                                                                                                                                                          | - 1            | 10a. State 10b. County 10c. City, Tow                                                                                 | n or Location                                                                                      |                            | 10d. Inside City Limits                                |  |  |  |
| V           | Maryland 28a-f show d at once.                                                                                                                                                                                                                                                                                               | 5              | District of Columbia Washi                                                                                            | ington                                                                                             |                            | 1 X Yes 2 No                                           |  |  |  |
| 11664       | Maryla<br>28a-f                                                                                                                                                                                                                                                                                                              | Director       | 10e. Street and Number                                                                                                | 10f. Zip Code                                                                                      | 10g.                       | Citizen of What Country?                               |  |  |  |
|             | h the l<br>3a or                                                                                                                                                                                                                                                                                                             | Ē              | 1255 Penn Street, NE #3                                                                                               | 20002                                                                                              |                            | United States                                          |  |  |  |
|             | th wit<br>ems 2                                                                                                                                                                                                                                                                                                              | uneral         | 11. Manital Status  1 X Never Married 2 Married 12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No              | <ol> <li>Was Decedent of Hispanic Origin? (S<br/>If Yes, specify Cuban, Mexican, Puerto</li> </ol> |                            | 14. Race - American Indian, Black, White, etc. African |  |  |  |
|             | er dea                                                                                                                                                                                                                                                                                                                       | F              | 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year                                                                     | 1 Yes 2 X No specify:                                                                              |                            | Specify: American                                      |  |  |  |
|             | rs afte                                                                                                                                                                                                                                                                                                                      | ğ              | lor Dates:                                                                                                            | Decedent's Usual Occupation (Give kind of                                                          | work done                  | 6b. Kind of Business/Industry                          |  |  |  |
|             | 72 hou                                                                                                                                                                                                                                                                                                                       | ompleted       | Elementary/Secondary (0-12) College (1-4 or 5+)                                                                       | during most of working life. DO NOT use ret                                                        | tired)                     |                                                        |  |  |  |
|             | 036<br>ithin<br>ne.<br>r than                                                                                                                                                                                                                                                                                                | E D            | 4 years                                                                                                               | Student                                                                                            |                            | Education                                              |  |  |  |
|             | 5-0<br>iled w<br>Hygic<br>the he                                                                                                                                                                                                                                                                                             | ပ၂             | 17. Tather S Hame (1 list, Middle, Edet)                                                                              |                                                                                                    | e (First, Middle, Mai      |                                                        |  |  |  |
|             | 21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica                                                                                                                                                                                                                                      | ) Be           | Walter Leon Skinner, Jr.  19a. Informant's Name/Relationship (Type, Print)                                            | 9b. Mailing Address (Street and Number or                                                          | ene B. Wir                 |                                                        |  |  |  |
|             | Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.        | ဥ              | Charlene B. Winn - Mother                                                                                             | 1255 Penn Street, NE                                                                               |                            |                                                        |  |  |  |
|             | and 2<br>and 2<br>Health<br>item 2<br>traus                                                                                                                                                                                                                                                                                  |                | 20a. Method of Disposition 20b. Place                                                                                 | e of Disposition (Name of cemetery,                                                                |                            | 20c. Location - City or Town, State                    |  |  |  |
|             | Baltimore,<br>bepartment of He<br>Important: If ite                                                                                                                                                                                                                                                                          |                | X Bullar 2 Cremation 3 Removal form state                                                                             | atory or other place) ony Mem. Park Feb                                                            | 27. 200                    | 08 Landover, MD                                        |  |  |  |
|             | nit. P<br>artme<br>sortan                                                                                                                                                                                                                                                                                                    |                | Donation 5 Other Specify: Harmo                                                                                       | 22. Name and Address of Facility St                                                                |                            |                                                        |  |  |  |
|             | Dep Per I                                                                                                                                                                                                                                                                                                                    | 8 13           | I to part of the miles                                                                                                | 4001 Benning Road                                                                                  |                            |                                                        |  |  |  |
|             | Physician                                                                                                                                                                                                                                                                                                                    |                | 23a. Part I. Enter the disease, or complications that caused the death. Do failule. List only one cause on each line. | not enter the mode of dying, such as cardiac                                                       | or respiratory arrest      | Between Onset and                                      |  |  |  |
| 0           | M. dical                                                                                                                                                                                                                                                                                                                     |                | Immediate Cause (Final disease a. Hanging                                                                             |                                                                                                    |                            | Death                                                  |  |  |  |
| •           |                                                                                                                                                                                                                                                                                                                              |                | or condition resulting in death)  Due to (or as a consequence of):                                                    |                                                                                                    |                            |                                                        |  |  |  |
|             |                                                                                                                                                                                                                                                                                                                              | ē              | Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):                          |                                                                                                    |                            |                                                        |  |  |  |
|             |                                                                                                                                                                                                                                                                                                                              | Examiner       | cause. Enter Underlying Cause (Dissasse or injury that initiated Due to (or as a consequence of):                     |                                                                                                    |                            |                                                        |  |  |  |
|             | ited<br>J<br>ansit                                                                                                                                                                                                                                                                                                           |                |                                                                                                                       |                                                                                                    |                            | ]                                                      |  |  |  |
|             | 760,<br>icate be executed<br>physician and<br>the burial - transit                                                                                                                                                                                                                                                           | Medical        | X UNPENDED AMENDED 23a,27,28a-f                                                                                       | per ME g878 4/9/08 amh                                                                             |                            |                                                        |  |  |  |
|             | 760, icate be physic the burn                                                                                                                                                                                                                                                                                                | Med            | IF FEMALE: 23c. If yes, outcome of pregnance                                                                          | су                                                                                                 |                            | 23d. Date of delivery                                  |  |  |  |
|             | 687<br>sertific<br>ding p                                                                                                                                                                                                                                                                                                    |                |                                                                                                                       | 2 Fetal death 3 Ectopic pregr                                                                      | nancy                      | Month Day Year                                         |  |  |  |
|             | Sox 687<br>death certific<br>e attending I                                                                                                                                                                                                                                                                                   | sician         | 1 Yes 2 No 9 Unknown g Unknown                                                                                        | 5 Other (Specify)                                                                                  |                            |                                                        |  |  |  |
|             | <b>Division of Vital Records, P.O. Box 68</b> to a Attending Physician: The law requires that the death certificate realth.  In Director: After this certificate has been signed by the attending to the funeral director, page 2 should be detached for use as                                                              | Phys           |                                                                                                                       | ting in the underlying cause given in Part I.                                                      | 23e. Did toba              | acco use contribute to the cause of death?             |  |  |  |
|             | P.(<br>res tha<br>signed<br>be det                                                                                                                                                                                                                                                                                           | d by           |                                                                                                                       |                                                                                                    | 1 Yes                      | 2 No 3 Probably 4 Unknown                              |  |  |  |
|             | rds<br>requi                                                                                                                                                                                                                                                                                                                 | Completed      |                                                                                                                       |                                                                                                    | 24a. Was an<br>autopsy     |                                                        |  |  |  |
|             | eco<br>he law<br>ite has<br>ige 2 s                                                                                                                                                                                                                                                                                          | μč             |                                                                                                                       |                                                                                                    | perform<br>1 ✓ Yes 2       |                                                        |  |  |  |
|             | In: T<br>ertifica<br>tor, pa                                                                                                                                                                                                                                                                                                 | O O            | 25. Was case referred to medical                                                                                      | 26.Place of Death (Check                                                                           | k only one)                |                                                        |  |  |  |
|             | Vita<br>hysicia<br>this ca<br>I direc                                                                                                                                                                                                                                                                                        | 0<br>B         |                                                                                                                       |                                                                                                    |                            | esidence 6 Other:                                      |  |  |  |
|             | n of<br>ling P<br>After<br>funera                                                                                                                                                                                                                                                                                            | n: T           | 27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)                                                           | b. Time of Injury 28c. Injury at Work?                                                             | 28d. Describe ho           | w injury occurred                                      |  |  |  |
|             | S OF<br>trend<br>death.<br>ctor:<br>y the                                                                                                                                                                                                                                                                                    | atic           | Pending   Fnd 2/18/08   Fr                                                                                            | id 9:29p                                                                                           | Subject as                 | phyxiated reet and Number or Rural Route Number, City  |  |  |  |
|             | ivis<br>for A<br>after<br>Dire                                                                                                                                                                                                                                                                                               | Certification: | 3 Suicide 6 X Could not be determined (Specify) House                                                                 | , farm, street, factory, office building, etc.                                                     | or Town, Sta               |                                                        |  |  |  |
|             | lospits<br>Hours<br>unera<br>ly fille                                                                                                                                                                                                                                                                                        |                |                                                                                                                       | death occurred at the time, date and place, an                                                     |                            |                                                        |  |  |  |
|             | Livis on of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after ceath.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as 1 | edical         | (Check only one)  2 Medical Examiner: On the basis of examination and/o                                               | or investigation, in my opinion, death occurred                                                    | at the time, date ar       | nd place, and due to the cause(s)                      |  |  |  |
|             | To<br>To                                                                                                                                                                                                                                                                                                                     | Med            | 29b. Signature and title of certifier                                                                                 | 29c. License number                                                                                |                            | 29d. Date signed (Month, Day, Year)                    |  |  |  |
| 1           |                                                                                                                                                                                                                                                                                                                              |                | Doma minimenti, mio.                                                                                                  | O.C.M.E.                                                                                           |                            | February 19, 2008                                      |  |  |  |
| 1           |                                                                                                                                                                                                                                                                                                                              |                | 30. Name and address of person who completed cause of death (Item 23                                                  |                                                                                                    |                            |                                                        |  |  |  |
| 12          |                                                                                                                                                                                                                                                                                                                              |                | Donna M. Vincenti, MD Assistant Medical Examin                                                                        | er 111 Penn Street, Baltimore, I                                                                   | MD 21201<br>—————          |                                                        |  |  |  |
|             |                                                                                                                                                                                                                                                                                                                              |                | 31. Date filed (Month, Day, Year)  FFR 2 5 2008  32. Registrar's Signature                                            | do                                                                                                 |                            |                                                        |  |  |  |
|             | Regis                                                                                                                                                                                                                                                                                                                        | Heli           | FEB 2 5 2000 Block to Apr                                                                                             |                                                                                                    |                            |                                                        |  |  |  |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 850 AM Month Vear **Physician** Wells-Rodrigues Tathi 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 3613 Holloway North Upper Marlboro If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 51 1956 Director 219-72-3274 December 24. Missouri Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □ Yes 2√□ No Director Maryland Anne Arundel Edgewater 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 3812 Ponder Drive 21037 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Yes 27 No If Yes, GiveX Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the IM. Legal Secretary Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Larry Keegan Carolyn Bryant Keegan ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Sean R. Rodrigues / Husband</u> 3812 Ponder Drive, Edgewater, MD 21037 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)

21. Signature Purply Stylice Licensee Lakemont Cemeterv 02/14/2008 Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home PA 2973 Solomons Island Road, Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3 years Juanan **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2**5** No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2.21No certificate has 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Mother's have 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ne Hospital or Attendi n 24 hours after death. ne Funeral Director: A death. 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

within 2 State Registrar

31. Date filed (Month, Day, Year) FEB 1 2 2008

29b. Signature and title of certifier

Bestarte Rd Sute 300 Annaples MD 900 32. Resistrar's Signature

and manner stated.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DV064379

29d. Date signed (Month, Day, Year)

2008

|                                                                                                                                                                 |                                                                                           |                                                                                                             | 1 - For State Registrar                                                                                                                                                                             | State of N                                                       | Marylan                                                                                                                                                                                                                     | -                                   | rtmen<br>tificate  |                                                                                                                                                                                                                                             |                                                          | and M        |                                                     | Reg. No.                                        | 008           | 0.6.3                           |                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------|-----------------------------------------------------|-------------------------------------------------|---------------|---------------------------------|-------------------------|
|                                                                                                                                                                 | Physici                                                                                   |                                                                                                             | n Anne Ashendorf February                                                                                                                                                                           |                                                                  |                                                                                                                                                                                                                             |                                     |                    |                                                                                                                                                                                                                                             |                                                          |              |                                                     | Day                                             | 2008          | 5:30                            | A M                     |
|                                                                                                                                                                 | /Medic<br>Examin                                                                          |                                                                                                             | 4a. Facility Name (If not institution, give s                                                                                                                                                       |                                                                  |                                                                                                                                                                                                                             |                                     | 4b. City,          | Town, or                                                                                                                                                                                                                                    | Location of                                              | of Death     |                                                     | 4                                               | inty of Death |                                 |                         |
|                                                                                                                                                                 |                                                                                           |                                                                                                             | Holy Cross Rehab 8                                                                                                                                                                                  |                                                                  |                                                                                                                                                                                                                             |                                     |                    |                                                                                                                                                                                                                                             | Vill∈                                                    |              |                                                     |                                                 | ntgome        | -d-                             |                         |
| l,                                                                                                                                                              | Funeral<br>Director                                                                       |                                                                                                             | 5. Social Security Number 6. Sex 059 10 4822                                                                                                                                                        | M 235 F                                                          | Age (In yrs.<br>95                                                                                                                                                                                                          | last birthday)<br>Yrs.              | If Under<br>Months | Days                                                                                                                                                                                                                                        | Hours                                                    | Min,         | 8. Date of Bird<br>(Month, Da<br>Dec. 15            | y, Year)                                        | Cou           | place (State ontry)<br>oslavi   |                         |
| 72 hours after death with the Maryland retural; or Iteme 23s or 28e-1 ehow dical Examinat ke notilied at                                                        | natural, or iteme 23a or 28e-f ebow<br>epical Examinar must be notilled at                | d by Funeral Director                                                                                       | 10a. State 10b. County  MD Howard  10e. Street and Number  10799 Hickory Ridd                                                                                                                       | 2. Was Decede<br>Armed Force<br>1 ☐ Yes 2 {<br>If Yes, Give      | 2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes, Give Year or Dates:  ation completed)  College (1-4or 5+)                                                                                                               |                                     |                    | Tof. Zip Code  21044  Vas Decedent of Hispanic Origin? (Specify Yes or Notes, specify Cuban, Mexican, Puerto Rican, etc.)  Yes, 2128No Specify:  Went's Usual Occupation Wind of work done during most of working NOT use retired)  memaker |                                                          |              | 1 □ Y  10g. Citizen of What Country?  United States |                                                 |               | intry? ites ican Indian, , etc. | City Limits<br>s 2X∑ No |
|                                                                                                                                                                 | al Hygiene. I other then "natu                                                            | Completed                                                                                                   | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)                                                                                                                   | completed)                                                       |                                                                                                                                                                                                                             |                                     |                    |                                                                                                                                                                                                                                             |                                                          |              | ing                                                 |                                                 | n Home        |                                 |                         |
| should be filed and Mental Hyge marked other umatic event,                                                                                                      | 2 20 6                                                                                    | To Be C                                                                                                     | 17. Father's Name (First, Middle, Last) Joseph Passo                                                                                                                                                |                                                                  |                                                                                                                                                                                                                             |                                     |                    |                                                                                                                                                                                                                                             | Regi                                                     | na (         | e (First, Middle,<br>Camhi                          |                                                 |               |                                 |                         |
| 3                                                                                                                                                               | ilth and 27 is m                                                                          | 7                                                                                                           | 19a. Informant's Name/Relationship (Ty)  Leah Amato/Daughte                                                                                                                                         |                                                                  |                                                                                                                                                                                                                             |                                     |                    |                                                                                                                                                                                                                                             | d Number or Rural Route Number, Ci<br>Circle Ellicott Ci |              |                                                     |                                                 |               |                                 |                         |
| ILITIONE, IN<br>lit. Pages 1 and 3<br>artment of Health                                                                                                         | perfill. Pages I and Department of Heal important: if item 2 eny injury or other page.    |                                                                                                             | 20a. Method of Disposition  1  Burial 2  Cremation 3  SR                                                                                                                                            |                                                                  |                                                                                                                                                                                                                             | ition (Name of atory or other place |                    |                                                                                                                                                                                                                                             |                                                          | Date         |                                                     | c. Location - City or Town, State               |               |                                 |                         |
|                                                                                                                                                                 | rtment<br>rtant: if                                                                       |                                                                                                             | 4 □ Donation 5 □ Other (Specify)                                                                                                                                                                    |                                                                  | Be                                                                                                                                                                                                                          | th Dav:                             | id Ce              | mete                                                                                                                                                                                                                                        | ry 2                                                     | -            | -2008                                               |                                                 |               | w York                          |                         |
|                                                                                                                                                                 | Depa<br>impo<br>eny ir                                                                    | ll i                                                                                                        | 21. Signature of Funeral Service License  23a. Part1. Enter the disease, or compli                                                                                                                  | Thy                                                              | M010                                                                                                                                                                                                                        | 41                                  | 112 0              | ld C                                                                                                                                                                                                                                        | olumk                                                    | oia I        | ry H. V<br>Pike El                                  | licott                                          |               |                                 | 1043                    |
| death certificate be executed  Weath certificate be executed  Example of attending physicien and attending physicien and attended for use as the burial-transit | /Medical<br>Examiner                                                                      | dical Examiner                                                                                              | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last | Due to (or                                                       | as a consectate as a consectate as a consectate as a consectate as a consectate as a consectate as a consectate as a consectate as a consectate as a consectate as a consectate as a consectate as a consectate as a consec | quence of):                         | γ,                 | <i>~</i> .∨                                                                                                                                                                                                                                 | m                                                        | inc          | · C ~ -                                             |                                                 |               | Onset and                       |                         |
|                                                                                                                                                                 |                                                                                           | Physician/Med                                                                                               | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown                                                                                                             | ast 12 prioriths?  4 Pregnant at time of death 5 Other (specify) |                                                                                                                                                                                                                             |                                     |                    |                                                                                                                                                                                                                                             |                                                          | 23d          | 23d. Date of delivery<br>Month Day Year             |                                                 |               |                                 |                         |
| The law requires that the de sie has been signed by the page 2 should be detached                                                                               | Completed by Ph                                                                           | Part II. Other significant continuously to death but not resulting in the underlying cause given in Part I. |                                                                                                                                                                                                     |                                                                  |                                                                                                                                                                                                                             |                                     |                    |                                                                                                                                                                                                                                             | prior to completion of cause of                          |              |                                                     |                                                 |               |                                 |                         |
|                                                                                                                                                                 |                                                                                           |                                                                                                             |                                                                                                                                                                                                     |                                                                  |                                                                                                                                                                                                                             |                                     |                    |                                                                                                                                                                                                                                             |                                                          |              | 1 ☐ Yes                                             | ormed?<br>20 No                                 | death?        | <b>2</b> € No                   |                         |
|                                                                                                                                                                 | ysicien:<br>ils certific<br>director,                                                     | o Be                                                                                                        | 25. Was case referred to medical examiner?  1 Yes 2 No                                                                                                                                              | lospital:                                                        | 26. Place of Death (tal. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ★ Nursing Home                                                                                                                                    |                                     |                    |                                                                                                                                                                                                                                             |                                                          |              |                                                     |                                                 |               |                                 |                         |
|                                                                                                                                                                 | trending rnys<br>death.<br>:tor: After this or<br>the funeral dir                         | H                                                                                                           | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation                                                                                                                                   | 28a. Date of<br>(Month,                                          |                                                                                                                                                                                                                             | 28b. Time o<br>Injury               |                    | 28c. Injun                                                                                                                                                                                                                                  |                                                          |              |                                                     | sidence 6 Other (Specify) a how injury occurred |               |                                 |                         |
| 2                                                                                                                                                               | ifter<br>Director                                                                         | Certification:                                                                                              | 3 Suicide 6 Could not be<br>4 Homicide determined                                                                                                                                                   | nome, larm, str                                                  | treet, lactory, office 281. Location (Stre                                                                                                                                                                                  |                                     |                    |                                                                                                                                                                                                                                             |                                                          | lumber or Ru | ıral Route Nu                                       | mber,                                           |               |                                 |                         |
| :                                                                                                                                                               | To the Hospitel or<br>within 24 hours after<br>To the Funeral Dir<br>completely filled in | Medical                                                                                                     | 29a. Certifier Check only 2 Medical Exami                                                                                                                                                           |                                                                  | is of examin.                                                                                                                                                                                                               |                                     |                    |                                                                                                                                                                                                                                             |                                                          |              |                                                     |                                                 |               |                                 | n(s)                    |
| :                                                                                                                                                               | vithin 2 To the complet                                                                   | Me                                                                                                          | 29b. Signature and title of certifier                                                                                                                                                               |                                                                  |                                                                                                                                                                                                                             | <del></del>                         | 1                  |                                                                                                                                                                                                                                             | number                                                   |              |                                                     |                                                 | •             | h, Day, Year)                   |                         |
|                                                                                                                                                                 |                                                                                           |                                                                                                             | 1                                                                                                                                                                                                   | 2                                                                |                                                                                                                                                                                                                             |                                     | C                  | 00                                                                                                                                                                                                                                          | 5-4                                                      | 56 6         | <b>&gt;</b> ,                                       | 2/1                                             | 5/08          |                                 |                         |
| (ط                                                                                                                                                              | Sta<br>Regist                                                                             | ate<br>rar                                                                                                  | 30. Name and address of person who con Sun the Bho 31. Date filed (Month, Day, Year) FEB 19 2                                                                                                       | 32/Ret                                                           | SU   C                                                                                                                                                                                                                      | eongie                              | Print)             | inic                                                                                                                                                                                                                                        |                                                          |              | 17,51                                               |                                                 |               | mo.                             | 2090                    |

Division or Vital Records, P.O. Box 68760.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1                                                                | For State Registrar                                                                                                               |                                                                                                                                                                  |                                    |                                       | ificate of l                                                 | Death                                      | -                                          | leg. No.                                                                   | 108                                      | 05390                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------|--------------------------------------------------------------|--------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------|
| Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1. Decedent's Name (First, Middle, Last)  Andrew Martin Burdette |                                                                                                                                   |                                                                                                                                                                  |                                    | · · · · · · · · · · · · · · · · · · · |                                                              | 2. Date of Dea<br>_Month                   | Day                                        | Year                                                                       | 3. Time of Death                         |                                                      |
| /Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                  | ANGREW  4a. Facility Name (If not institution, give                                                                               | 4b. City, Town, or                                                                                                                                               | Location of Death                  | FEBRUAL                               | -                                                            | 2008                                       |                                            |                                                                            |                                          |                                                      |
| LAdillile                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                  | The Johns Hopkins                                                                                                                 | Hosp.tal                                                                                                                                                         |                                    |                                       | BAITIM                                                       | ore cit                                    | Υ                                          |                                                                            |                                          |                                                      |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                  | 5. Social Security Number  None  1  Usual Residence of Decedent                                                                   | ex 7. Age                                                                                                                                                        | e (In yrs. last birtf<br>Y         |                                       | If Under 1 Year Months Days 1                                | If Under 24 Hrs. Hours Min.                | 8. Date of Birth<br>(Month, Day<br>Feb 24, | <sup>1</sup> , Year)<br>2008                                               | 9. Birth                                 | nplace (State or Foreign<br>untry)<br><b>lan</b> d   |
| yland<br>now<br>at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                  | 10a. State 10b. County                                                                                                            | 1                                                                                                                                                                | 10c. City, Town                    |                                       |                                                              |                                            |                                            |                                                                            |                                          | 10d. Inside City Limits                              |
| Ba-f st                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 5                                                                | Maryland Frederi                                                                                                                  | CK                                                                                                                                                               | Fre                                | deri                                  | ,                                                            |                                            |                                            |                                                                            |                                          | 1 ☐ Yes 2 <b>X</b> No                                |
| ifter death with the Mainter death with the Mainter Etems 23a or 28a-f sininer must be notified                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  | 10e. Street and Number 5818 Shookstown Road 10f. Zip Code 21702                                                                   |                                                                                                                                                                  |                                    |                                       |                                                              |                                            |                                            | S.A.                                                                       |                                          |                                                      |
| xan xan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 5                                                                | 11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                                                        | 12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri |                                    |                                       |                                                              | ecify Yes or No-<br>Rican, etc.)           | Bla                                        | ace - Amer<br>ack, White<br>ity: Wh                                        |                                          |                                                      |
| ed within 72 hor<br>ygiene.<br>her than "natura<br>it, the Medical E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | - Indian                                                         | 15. Decedent's Ed<br>(Specify only highest grade)<br>Elementary/Secondary (0-12)                                                  | lucation<br>de completed)<br>College (1-4or 5-                                                                                                                   |                                    | (Give ki<br>life. D0                  | ent's Usual Occup<br>ind of work done on<br>ONOT use retired | ation<br>during most of work<br>t)         | ing                                        | 16b. Kind of I                                                             | Business/I                               | ndustry                                              |
| be filed trail Hyging dother event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, to event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event |                                                                  | 17. Father's Name (First, Middle, Last)                                                                                           |                                                                                                                                                                  | D 1                                | -                                     |                                                              | 18. Mother's Name                          |                                            | _                                                                          | ,                                        |                                                      |
| d Menide Manke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 2                                                                | Joseph C                                                                                                                          |                                                                                                                                                                  | Burdette                           |                                       | Jr                                                           | Tracey and Number or Run                   |                                            |                                                                            | Bened                                    |                                                      |
| 1 and 2 s<br>Health an<br>m 27 is i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                  | Mr. Joseph Burdet                                                                                                                 |                                                                                                                                                                  | ather 5                            | 818                                   | Shookst                                                      | own Road,                                  | Freder                                     | ick, M                                                                     | aryla                                    | and 21702                                            |
| : Pages<br>tment of tant: If the<br>tant: If the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                  | 20a. Method of Disposition  1 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif.                                           | y)                                                                                                                                                               |                                    | vet                                   | tion (Name of<br>atory or other place<br>Cemetery            | 7 Feb 29                                   | ,2008 I                                    | 20c. Location<br>rederi                                                    | ick,                                     | Maryland                                             |
| Depar<br>Important in any ir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                  | 21. Signature of Funeral Service Cider                                                                                            |                                                                                                                                                                  | 00706                              | 10                                    | Name and Addres<br>Keeney<br>)6 East (                       | & Basfor<br>Church St                      | d P.A. I                                   | Tuneral                                                                    | l Hom                                    | e<br>and 21701                                       |
| 100 A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                  | 23a. Part1. Enter the disease, or com shock, or heart failure. List only                                                          |                                                                                                                                                                  |                                    | ot enter                              | the mode of dyin                                             | g, such as cardiac                         | or respiratory an                          | rest,                                                                      | rai y i                                  | Approximate<br>Interval Between                      |
| Physician<br>/Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                  | Immediate Cause (Final disease or condition resulting in death)                                                                   | a. Pulma                                                                                                                                                         | YIAU                               | HY                                    | poplas                                                       | , A                                        |                                            |                                                                            |                                          | Onset and Death                                      |
| Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                  | Sequentially list conditions                                                                                                      | b. Conse                                                                                                                                                         | a consequence o                    | i):                                   | Aphragn                                                      | natic He                                   | INIA                                       |                                                                            |                                          | 24 hours                                             |
| executed in and ial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or)as a                                                                                                                                                  | Atur.t                             | f):<br>{                              | ,                                                            |                                            |                                            |                                                                            |                                          | 24 hours                                             |
| rificate be executed ng physiclan and as the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                  | resulting in death) Last                                                                                                          | Due to (or as a                                                                                                                                                  | a consequence o                    | f):                                   |                                                              |                                            |                                            |                                                                            |                                          |                                                      |
| ertifica<br>ling ph<br>e as th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | -                                                                | IF FEMALE:                                                                                                                        | 00- 1/                                                                                                                                                           |                                    |                                       | . <u>.</u>                                                   |                                            |                                            |                                                                            |                                          |                                                      |
| The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the bunal-transit completed by Physician/Medical Fxamir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                  | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                                                      | 23c. If yes, outcome p<br>1 ☐ Live birth<br>4 ☐ Pregnant at<br>9 ☐ Unknown                                                                                       | 2 Fetal death                      |                                       | Ectopic preg <b>nanc</b> y<br>Other <i>(specify)</i>         |                                            |                                            |                                                                            | ate of deli<br>Month                     | very<br>Day Year                                     |
| res that igned be deta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                  | Part II. Other significant conditions of                                                                                          | ontributing to death bu                                                                                                                                          | t not resulting in                 | the und                               | lerlying cause give                                          | en in Part I.                              | 23e. Did to                                | bacco use co                                                               | se contribute to the cause of death?     |                                                      |
| w requir<br>been si<br>should                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                  |                                                                                                                                   |                                                                                                                                                                  |                                    |                                       |                                                              |                                            | 1 🗆 Y                                      | es X No                                                                    | 3 🗆 Pr                                   | obably 4 Unknown                                     |
| : The law requi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |                                                                                                                                   |                                                                                                                                                                  |                                    |                                       |                                                              | **                                         | 24a. Was a autop perfor                    | sy                                                                         | o. Were au<br>prior to death?<br>1 ☐ Yes | topsy findings available completion of cause of 2 No |
| ysiclan: The sis certificate director, pag                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1                                                                | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No                                                                           | Hospital: Inpatier                                                                                                                                               | nt 2 ☐ ER/Out                      | nationt                               | 3□ DOA Oth                                                   | 26. Place of Deat                          |                                            |                                                                            |                                          |                                                      |
| ter this neral d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                  | 27. Manner of Death  Natural 5 □ Pending                                                                                          | 28a. Date of Injur<br>(Month, Day                                                                                                                                | y 28b. T                           |                                       | 28c. Injur<br>Worl                                           |                                            | me 5 Resid<br>28d. Describe h              | -                                                                          |                                          | erfy)                                                |
| ttendir<br>feath.<br>stor: At<br>the fu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                  | 2 Accident investigation                                                                                                          |                                                                                                                                                                  |                                    |                                       | M 1 🗆                                                        | Yes 2□No                                   |                                            |                                                                            |                                          |                                                      |
| ttal or Attending rs after death. ral Director: Afte led in by the fune                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                  | 4 ☐ Homicide determined                                                                                                           | 28e. Place of inju<br>building, etc                                                                                                                              | ry - At nome, fari<br>:. (Specify) | m, stree                              | et, ractory, office                                          |                                            | 28f. Location (S<br>City or Tow            | Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                          |                                                      |
| To the Hospital or Attending Physician: within 24 hours after deart. To the Funeral Director: After this certifica completely filled in by the funeral director; Medical Certification: To Be C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  | 29a. Certifier  (Check only one)  Certifying Ph  2 ☐ Medical Exar                                                                 | ysician: To the best on<br>niner: On the basis of<br>and manner sta                                                                                              | examination and                    | death<br>dor inve                     | occurred at the tirestigation, in my o                       | ne, date and place,<br>pinion, death occur | and due to the ored at the time,           | cause(s) and r<br>date and place                                           | manner as<br>e, and due                  | stated. to the cause(s)                              |
| To t<br>Within<br>To tl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                  | 29b. Signature and title of certifier                                                                                             | CM                                                                                                                                                               |                                    |                                       | 29c. Licens                                                  | 3911                                       |                                            | Pebrua                                                                     | 1 2                                      | h, Day, Year) 5 2008                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  | 39. Name and address of person who I) r. AN Stone MO                                                                              | completed cause of de                                                                                                                                            | eath (Item 23a) (1                 | Type, P                               | nint)  int B                                                 | Alt. morf                                  | HD 3                                       | 11287                                                                      |                                          |                                                      |
| State<br>Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                  | 31. Date filed (Month, Day, Year) MAR 0 3                                                                                         | 2008 32. Registra                                                                                                                                                | r's Signature                      | A                                     | serte                                                        |                                            |                                            |                                                                            |                                          |                                                      |

Thomas Joseph Mulhall

19a. Informant's Name/Relationship (Type. Print)

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If Item 27 is marked other any injury or other traumatic event, # **Physician** /Medical

Examiner

and

attending physician

the

as

Division or Vital Records. P.O. Box 68760.

CarolAnn Sommer/ Daughter 2571 Davidsonville Rd., Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Bluff Cemetery | 2/15/08 4 Donation 5 Other (Specify) Annapolis, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home Mul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes S No
9 ☐ Unknown Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifle 29d. Date signed (Month, Day, Year)

Beatrice Tighe

ENSE HOHWAY A NOVAPOLISM D LIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Registrar

eted cause of death (Item 23a) (Type Rrint)

ame and address of ner

e Hospital or Attend! 24 hours after death. e Funeral Director: /

24

To the I

Registrar

31. Date filed (Month, Day, Year)

32 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Jack BROOKES 5:45 P M 12, 2008 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 □ F Yrs. 5, 1917 Director 90 113-12-4594 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Montgomery Darnestown Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20878 United States 14509 Falling Leaf Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Mantal Status Black, White, etc. 72 hours after 1 Y Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. th and Mental Hygiene. To is marked other than "no Elementary/Secondary (0-12) College (1-4or 5+) Contracting Contractor 18. Mother's Name (First, Middle, Maiden Surname)
Tillie Birsch Maryland 17. Father's Name (First, Middle, Last) Be Saul Brookes P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai 20878 14509 Falling Leaf Ct., Darnestown, MD Stefani Culver, Daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 01/14/08 Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home To be 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Rhabdomyolysis disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 3 Days Acute Vascular Occlusion Right Leg Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed Years Peripheral Arterial Disease and the burial-tran Due to (or as a consequence of) 68760, attending physician Years Chronic Renal Failure Physician/Medical for use as Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown signed by نم 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has page 2 The this certificate Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 9 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division After (Month, Day Year) Attending 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death filled in by the 6 ☐Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 6 Hospital within 24 hours a 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) February 13, 2008 29b. Signature and title of certifier 29c. License number D 24773 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, Rockville, MD Robert L. Fox, M.D.,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 14 2008

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** J. Brown February 14, 2008 19:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2X F Director July 22, 1920 Washington, DC 579-26-4215 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County worle 27 is marked other than "natural", or Itema 23a or 28a-f ebov traumatic event, the Madical Examinat must be notified at 1 X Yes 2 ☐ No Directo District of Columbia Washington 10f. Zip Code 10g. Citizen of What Country? 20019 4318 Gorman Terrace, SE United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: **Black** 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry l Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Postal Service\_Clerk Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental I Howard Johnson Irene Dunnington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3310 Clavier Place Clinton, MD 20735 Health Item 27 Joseph G. Brown, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of I Department of Important: If It any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery Feb. 22, 2008 Brentwood, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral S 4001 Benning Road, NE Washington, DC 20019 Approximate Interval Between Onset and Death 23a. Part 1 Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or lear failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine use as the burial-transit resulting in death) Last Due to (or as a consequence of) physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 4 Unknown 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 27 No 2 1 TYes funeral director. 25. Was case referred to medical Be 26. Place of Death | Check only one 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Certification: To No 1 Ciccationt 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mariner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

or Attending

Hospital

Baltimore, Maryland 21215-0036

certificate be executed

Box 68760

P.O.

Division of Vital Records.

State Registrar

31. Date filed (Month, Day, Year) FEB 19

30. Name and address of person who

29b. Signature and title of certifier

mplet use of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year,

State

31. Date filed (Month, Day, Year) FEB 1 9 2008

29b. Signature and title of certifier



MD

Registrar

29c. License number

D0064760

29d. Date signed (Month, Day, Year)

February 13, 2008

|             |                                                                                                                                                                                                                                                                                                                                                                                                    | 1                   | For<br>State<br>Registrar                                                                                                                                  | State of Maryla                                                                              |                                                                                            | artment of F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                            |                                                   | iene<br><sub>eg. N</sub> 2 0 0 8                 | 06396                                              |                  |  |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------|--------------------------------------------------|----------------------------------------------------|------------------|--|
|             | Physicia<br>/Medic                                                                                                                                                                                                                                                                                                                                                                                 | an<br>al            | 1. Decedent's Name (First, Middle, Las                                                                                                                     | ORWELL                                                                                       | BUAGL                                                                                      | Mer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | SR                                         | 2. Date of Deat                                   | 18 25 8 g                                        | 3. Time of Death                                   |                  |  |
|             | Examin                                                                                                                                                                                                                                                                                                                                                                                             | er                  | 4a. Facility Name (If not institution, gives 14508 Blairs                                                                                                  | valley Road                                                                                  | d<br>rrs. last birthday)                                                                   | 4b. City, Town, o Cleat  If Under 1 Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | c Sprin                                    | ıg,                                               | Washingt                                         | On Diace (State or Foreign                         |                  |  |
|             | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                |                     | 5. Social Security Number 214-14-6848 6. Solution 1                                                                                                        | M 2□ F 9(                                                                                    |                                                                                            | Months Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                            |                                                   | , 1917 Ma                                        | aryland                                            |                  |  |
|             | Maryland<br>-f show                                                                                                                                                                                                                                                                                                                                                                                |                     | MD Washin                                                                                                                                                  |                                                                                              | City, Town or Lo                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            |                                                   |                                                  | 10d. Inside City Limits 1 ☐ Yes 🎢 No               |                  |  |
|             | th with the<br>23a or 28s                                                                                                                                                                                                                                                                                                                                                                          | al Direc            | 10e. Street and Number<br>14508 Blairs                                                                                                                     | valley Rd                                                                                    |                                                                                            | 10f. Zip Code<br>2172                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                            |                                                   | Og. Citizen of What Cou                          |                                                    |                  |  |
| 980         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene importent: If item 27 is marked other then "naturel", or items 23a or 28a-f show importent: If item 27 is marked other the "health and mary righty or other treumatic event, its Medical Examinat must be a cilified at ance. | by Fur              | 11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced                                                                                 | 12. Was Decedent Ever in<br>Armed Forces?<br>1 □Yes 2 □YNo<br>If Yes, Give<br>Year or Dates: |                                                                                            | Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2 ※ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                            | (Specify Yes or No-<br>erto Rican, etc.)          | 14. Race - Ameri<br>Black, White<br>Specify: Whi | ite                                                |                  |  |
| 21215-0036  | d within 72 ho<br>plene.<br>r then "natur<br>the Medical                                                                                                                                                                                                                                                                                                                                           | Completed           | 15. Decedent's Ec<br>(Specify only highest gra<br>Elementary/Secondary (0-12)<br>6th grade                                                                 | lucation<br>de completed)<br>College (1-4or 5+)                                              | 16a. Dece<br>(Give<br>life.<br>farn                                                        | dent's Usual Occup<br>kind of work done<br>DO NOT use retire<br>Ner-timb                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | pation<br>during most of w<br>d)<br>Oerman | working                                           | self emp                                         | •                                                  |                  |  |
| Maryland 2  | 2 should be filed<br>and Mental Hygin<br>is marked other<br>reumatic event,                                                                                                                                                                                                                                                                                                                        | To Be C             | 17. Father's Name (First, Middle, Last)<br>Frank Braguni                                                                                                   | er                                                                                           |                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 18. Mother's N<br>Marth                    | Name (First, Middle, 1)                           | Maiden Sumame)<br>e 1 1                          |                                                    |                  |  |
|             | 1 and 2 shored Health and N Health and N I was 27 is mather treums                                                                                                                                                                                                                                                                                                                                 |                     | 19a. Informant's Name/Relationship (<br>Thelma Bragun                                                                                                      | ier wife                                                                                     | 1450                                                                                       | 08 Blair                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | rsvalle                                    | ey Rd.Cle                                         | r, City or Town, State, Zi<br>ear Spring         | g,MD 21722                                         |                  |  |
| Baltimore,  | Pages 1 and the nent of He ent: If iten ury or oth                                                                                                                                                                                                                                                                                                                                                 |                     | 20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify)                                                                 | Removal from State                                                                           |                                                                                            | matory or other pla<br>valley (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Jem. 2                                     | 2008                                              | 20c. Location - City or T<br>Clear Spr:          | ing,MD                                             |                  |  |
| Balt        | permit. Pag<br>Department<br>Importent: I<br>any injury o                                                                                                                                                                                                                                                                                                                                          |                     | 21. Signature of Funeral Service Licer                                                                                                                     | Lien                                                                                         |                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            |                                                   | Funeral Ing, MD 21                               |                                                    |                  |  |
| 4           | Pnysician                                                                                                                                                                                                                                                                                                                                                                                          |                     | 23a. Part1. Enter the disease, or com<br>shock, or hear bailure. List only<br>Immediate Cause (Final<br>disease or condition                               | plications the caused to e done cause of each line.                                          | leath. Do not en                                                                           | LAVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | /                                          | fac or respiratory ari                            | rest,                                            | Approximate<br>Interval Between<br>Onset and Death |                  |  |
|             | /Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                               | _                   | resulting in death)  Sequentially list conditions,                                                                                                         | b. Attack                                                                                    | sequence of):                                                                              | fic co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | VONA                                       | AAR                                               | disets2                                          |                                                    |                  |  |
| _           | ite be executed<br>iysician and<br>ne burial-transit                                                                                                                                                                                                                                                                                                                                               | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | cDue to (or as a con                                                                         | sequence of):                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            | <i>b</i>                                          |                                                  |                                                    |                  |  |
| 68760,      | eath certificate be executed attending physician and for use as the burial-transit                                                                                                                                                                                                                                                                                                                 | Physician/Medical E | icai                                                                                                                                                       | icai                                                                                         |                                                                                            | d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                            |                                                   |                                                  |                                                    |                  |  |
| .O. Box     | requires that the death certifica<br>een signed by the attending ph<br>hould be detached for use as th                                                                                                                                                                                                                                                                                             |                     |                                                                                                                                                            | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No                     | 23c. If yes, outcome of pre<br>1 ☐ Live birth 2 ☐ F<br>4 ☐ Pregnant at time<br>9 ☐ Unknown | Fetal death 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | □Ectopic pregnand □ Other (specify) _      | су                                                |                                                  | 23d. Date of deli<br>Month                         | very<br>Day Year |  |
| Д           | uires that<br>n signed b                                                                                                                                                                                                                                                                                                                                                                           | þ                   | Part II. Other significant conditions of                                                                                                                   | contributing to death but not                                                                | t resulting in the t                                                                       | underlying cause gi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | iven in Part I.                            | 23e. Did to                                       | obacco use contribute to<br>′es 2 ¥ No 3 □ Pro   | the cause of death?                                |                  |  |
| Records,    | has<br>6.2                                                                                                                                                                                                                                                                                                                                                                                         | Completed           | Cerehrai                                                                                                                                                   | VASIMA                                                                                       | v d                                                                                        | sease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ,                                          | 24a. Was<br>autop<br>perfor<br>1 \( \triangle Yes | rmed? prior to death?                            | topsy findings available ompletion of cause of     |                  |  |
| Vital       | Physicien: The r this certificate ral director, pag                                                                                                                                                                                                                                                                                                                                                | To Be C             | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No                                                                                                  | Hospital: 1 ☐ Inpatient                                                                      | 2 ☐ ER/Outpatie                                                                            | int 3□ DOA Of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 26. Place of I                             | Death (Check only o                               | ne)                                              | erfy)                                              |                  |  |
| on of       | ling<br>After<br>fune                                                                                                                                                                                                                                                                                                                                                                              |                     | 27. Manner of Death  Natural 5 Pending Compared investigation                                                                                              | 28a. Date of Injury<br>(Month, Day Yea                                                       | 28b. Time (Injury                                                                          | Wo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | uryat<br>ork?<br>∐Yes 2 ∐No                | 28d. De cribe h                                   | now injury occurred                              |                                                    |                  |  |
| Division of | or Attending after death. I Director: After din by the fune                                                                                                                                                                                                                                                                                                                                        | Certification:      | 3 Suicide 6 Could not be determined                                                                                                                        | e 280 Place of Injury -                                                                      | At home, farm, stoecify)                                                                   | treet, factory, office                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 9                                          | 28f. Location (S<br>City or Ton                   | Street and Number or Ru<br>vn, State)            | ral Route Number,                                  |                  |  |
|             | To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the                                                                                                                                                                                                                                                                                         | edical C            | 29a. Certifier Certifying Pl<br>(Check only one) 2 Medical Example (Check only one)                                                                        | nysician: To the best of my<br>niner: On the base of exar<br>and manyer stated.              | knowledge, dea<br>mination and/or i                                                        | th occurred at the three three transfers of the three transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the transfers of the tra | time, date and pl<br>opinion, death o      | occurred at the time,                             | date and place, and due                          | to the cause(s)                                    |                  |  |
|             | To the within 2 To the comple                                                                                                                                                                                                                                                                                                                                                                      | M                   | 29b. Signature and title of certifier                                                                                                                      | eno                                                                                          |                                                                                            | 29c. Licer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 72657                                      | 2-3                                               | 29d. Date signed (Month                          | n, Pay, Year)                                      |                  |  |
| Ja          | 3                                                                                                                                                                                                                                                                                                                                                                                                  |                     | 30. Name and address of pers in who                                                                                                                        | Mouth 1                                                                                      | 10 11                                                                                      | 115 ME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | dies                                       | CAPP                                              | TROND                                            | W                                                  |                  |  |
|             | Sta<br>Regist                                                                                                                                                                                                                                                                                                                                                                                      | ate<br>rar          | FEB 2 0 2008                                                                                                                                               | 32. Pegistrar's S                                                                            | ignature                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            | t to                                              | FIGLAN.                                          | 12/742                                             |                  |  |

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Funeral Director

|                               | **                                                                                                          | ck Indelible Ink. Ensure All                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              | •                                      |                                                 |  |  |  |
|-------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------------------|-------------------------------------------------|--|--|--|
|                               | State of Maryland /                                                                                         | Department of Health and Me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ental Hygien                                 | e2008                                  | 06397                                           |  |  |  |
|                               | Registrar                                                                                                   | Certificate of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Reg. N                                       | o.                                     | 3. Time of Death                                |  |  |  |
| n<br>al                       | 1. Decedent's Name (First, Middle, Last) Florence L. Becker                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              | ay Joos                                | 0.1111 Au                                       |  |  |  |
| er                            | 4a. Facility Name (If not institution, give street and number)                                              | 4b. City, Town, or Location of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4                                            | 4c. County of Death                    |                                                 |  |  |  |
| d                             | ATANTIC General Mospital                                                                                    | birthday) If Under 1 Year   If Under 24 Hrs.   g                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | B. Date of Birth                             | worce                                  |                                                 |  |  |  |
|                               | 5. Social Security Number 6. Sex 7. Age (In yrs. last I                                                     | Months Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (Month, Day, Yea                             | r) Co                                  | nplace (State or Foreign<br>untry)              |  |  |  |
|                               | Usual Residence of Decedent                                                                                 | PI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | AI 1.J, 19                                   | ZU WASH                                | INGTON, D.C.                                    |  |  |  |
|                               |                                                                                                             | own or Location                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              |                                        | 10d. Inside City Limits                         |  |  |  |
| ģ                             | DELAWARE SUSSEX SE                                                                                          | LBYVILLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              |                                        | 1 ☐ Yes 2X No                                   |  |  |  |
| Lec                           | 10e. Street and Number                                                                                      | 10f. Zip Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10g. C                                       | itizen of What Co                      | untry?                                          |  |  |  |
| <u>a</u>                      | 37251 EAST STONEY RUN                                                                                       | 19975                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                              | USA                                    |                                                 |  |  |  |
| ner                           | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?                                              | 13. Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ri                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ify Yes or No-                               | 14. Race - Ame<br>Black, White         |                                                 |  |  |  |
| Completed by Funeral Director | 1 ☐ Never Married 2 【XMarried 1 ☐ Yes 2 X No<br>If Yes, Give                                                | 1 ☐ Yes 2 XNo Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | , , , , , ,                                  | 0                                      |                                                 |  |  |  |
| g<br>D                        | 3 Widowed 4 Divorced Year or Dates:                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              | W                                      | HITE                                            |  |  |  |
| ete                           | 15. Decedent's Education (Specify only highest grade completed)                                             | a. Decedent's Usual Occupation<br>(Give kind of work done during most of working                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 16b.                                         | Kind of Business/                      | Industry                                        |  |  |  |
| d L                           | Elementary/Secondary (0-12) College (1-4or 5+)                                                              | life. DO NOT use retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              | 0171 1101                              | <b></b>                                         |  |  |  |
|                               | 17. Father's Name (First, Middle, Last)                                                                     | HOMEMAKER  18. Mother's Name (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | First Middle Maide                           | OWN HO                                 | 1E                                              |  |  |  |
| Be                            | MILTON OTTERBACK                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              |                                        |                                                 |  |  |  |
| ٥                             |                                                                                                             | OLLIE 9b. Mailing Address (Street and Number or Rural)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                              | GINTON                                 | in Code)                                        |  |  |  |
|                               |                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              |                                        |                                                 |  |  |  |
| 1                             | 20a. Method of Disposition 20b. Place                                                                       | 37251 EAST STONEY RUN of Disposition (Name of Day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                              | Le DE                                  |                                                 |  |  |  |
| 3                             | 1 Burial 2 Cremation 3 Removal from State                                                                   | tery, crematory or other place)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (00 BE                                       |                                        |                                                 |  |  |  |
| 1                             | 4 □Donation 5 □Other (Specify) CREMA'  21. Signatury of Frineral Septice Licensee                           | TORY OF DELMARVA 2/14/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | U8 DEI                                       | LMAR, DEI                              | LAWARE                                          |  |  |  |
|                               | 21. Signatury of menal solvice cicolises                                                                    | HASTINGS FUNERAL HOM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TE SEIRV                                     | TITE DI                                | 7 10075                                         |  |  |  |
|                               | 23a. Part1. Enter the disease, or complications that caused the death. D                                    | <u> </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              | VIDDE, D                               | Approximate                                     |  |  |  |
|                               | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final                          | N-01-11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1141 -                                       |                                        | Interval Between<br>Onset and Death             |  |  |  |
|                               | disease or condition resulting in death)                                                                    | in Ditticile (0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | IIIIS                                        |                                        |                                                 |  |  |  |
|                               | Due to (or as a consequence                                                                                 | ( T ( ) )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              |                                        |                                                 |  |  |  |
| ē                             | Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence)                 | e of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                              |                                        |                                                 |  |  |  |
| Examine                       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Artery Disea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 50                                           |                                        |                                                 |  |  |  |
| EX                            | that initiated events c. Due to (or as a consequence                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              |                                        |                                                 |  |  |  |
| ca                            | d                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              |                                        |                                                 |  |  |  |
| Physician/Medical             | 153                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              |                                        |                                                 |  |  |  |
| 2                             | IF FEMALE:  23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal dea                                        | th 3 Ectopic pregnancy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                              | 23d. Date of del                       |                                                 |  |  |  |
| )<br> <br> <br>               | in the past 12 months?  1   Yes   2   5   No   9   Unknown                                                  | 5 Other (specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                              | Month                                  | Day Year                                        |  |  |  |
| چ                             | 9 Unknown 9 Unknown                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              |                                        |                                                 |  |  |  |
|                               | Part II. Other significant conditions contributing to death but not resulting                               | in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 23e. Did tobacco                             | . /                                    | the cause of death?                             |  |  |  |
| e                             |                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 Tes                                        | 2 <b>2 6</b>                           | obably 4 Unknown                                |  |  |  |
| pe                            |                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 24a. Was an autopsy                          | 24b. Were au                           | topsy findings available completion of cause of |  |  |  |
| Completed by                  |                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | performed?                                   | death?                                 | 2□ No                                           |  |  |  |
| ge R                          | 25. Was case referred to medical examiner?                                                                  | 26. Place of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (Check only one)                             |                                        |                                                 |  |  |  |
| 0                             | HOSDITAL:                                                                                                   | Outpatient 3 DOA Other: 4 Nursing Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | e 5 🗆 Residence                              | 6 ☐Other (Spec                         | cify)                                           |  |  |  |
| <br>                          | 27. Manner of Death 28a. Date of Injury 28b.  DaNatural 5 □ Pending (Month, Day Year)                       | o. Time of 28c. Injury at 28<br>Injury Work?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | d. Describe how in                           | jury occurred                          |                                                 |  |  |  |
| ğ                             | 2 Accident investigation                                                                                    | M 1 Tyes 2 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                              |                                        |                                                 |  |  |  |
| Ē                             | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, building, etc. (Specify)            | farm, street, factory, office                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Rf. Location (Street and City or Town, Sta   | and Number of Ru<br>ite)               | iral Route Number,                              |  |  |  |
| 2                             |                                                                                                             | L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                              |                                        |                                                 |  |  |  |
| edical Certification:         | 29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and manner stated.         | ige, death occurred at the time, date and place, ar<br>and/or investigation, in my opinion, death occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | id due to the cause<br>d at the time, date a | (s) and manner as<br>nd place, and due | to the cause(s)                                 |  |  |  |
| Me                            | 29b. Signature and title of certifies                                                                       | 29c. License number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 29d. D                                       | Date signed (Mont                      | h, Day, Year)                                   |  |  |  |
|                               | Mark X/M/ A MA                                                                                              | NEUGUE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 3                                            | 1 1.0                                  | •                                               |  |  |  |
|                               | and the good of the good of the time of                                                                     | Dayay Stipt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 0                                            | 113/08                                 |                                                 |  |  |  |
|                               | 3. Name and coress of person who completed cause of death (Item 23a                                         | Was done Roll                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | J MOO                                        | 218                                    | 3//                                             |  |  |  |
| e                             | 31. Date filed (Month, Day, Year)  32. Restrar's Signature                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | - 1 11                                       | 000                                    |                                                 |  |  |  |
| r                             | FEB 15 2008                                                                                                 | 1 descho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              |                                        |                                                 |  |  |  |
| 11                            | Jan Ja                                                                                                      | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | ·                                            |                                        |                                                 |  |  |  |

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| JV.                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | Decedent's Name (First, Middle, La                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | st)                                              |                                     |                                                                |                                           | 2. Date of De                       | ath               |                             | 3. Time of                           | Death       |
| П                   | Physici                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | Howard,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                  |                                     |                                                                | Byrd                                      | February                            | Day               | Year                        | 1857                                 | М           |
|                     | /Medio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 4a. Facility Name (If not institution, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                  |                                     |                                                                | or Location of Deat                       | h /                                 |                   | unty of Death               | 1                                    |             |
|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 5. Social Security Number 6.5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | pital                                            |                                     | Baltin                                                         | ore Lit                                   |                                     |                   |                             |                                      |             |
|                     | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                  | (In yrs. last birthday) Yrs.        | Months Days                                                    | If Under 24 Hrs.<br>Hours Min.            | (Month, Da                          | y, Year)          |                             | place (State or<br>intry)            | r Foreign   |
|                     | Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | 346–32–5087 Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | XJM 2LIF 67                                      | 115.                                |                                                                |                                           | Nov 25                              | , 1940            | )   I                       | L                                    |             |
|                     | /land<br>ow<br>at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 10a. State 10b. County                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                  | 10c. City, Town or Lo               | ocation                                                        |                                           |                                     |                   |                             | 10d. Inside Cit                      | y Limits    |
|                     | Mary<br>a-f sh<br>fied                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 혅                | MD Balt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | imore                                            | Pikesvil                            | le                                                             |                                           |                                     |                   |                             | 1 X Yes                              | 2 □ No      |
|                     | th the<br>or 28;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ire              | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                  |                                     | 10f. Zip Code                                                  |                                           |                                     | 10g. Citizen      | of What Cou                 | intry?                               |             |
|                     | 23a ust b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Funeral Director | 7207 Brook Crest                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <del></del>                                      |                                     | 21208                                                          |                                           |                                     |                   | USA                         |                                      |             |
|                     | tems                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | nue              | 11. Marital Status                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 12. Was Decedent E<br>Armed Forces?              | ver in U.S. 13.                     | Was Decedent of I<br>If Yes, specity Cub                       | Hispanic Origin? (S<br>ban, Mexican, Puer | pecify Yes or No<br>to Rican, etc.) | - 14.             | Race - Amer<br>Black, White |                                      |             |
| 36                  | s afte                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | by F             | 1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates: | 2                                   | 1□Yes 🏖 No                                                     | Specify:                                  |                                     | Sp                | pecify: Bla                 | ck                                   |             |
| 21215-0036          | filed within 72 hours after death with the Maryland<br>Hygiene.<br>wther than "natural", or items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ed               | 15. Decedent's E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 16a. Dece                           | dent's Usual Occu                                              | pation                                    |                                     | 16b. Kind         | of Business/I               | ndustry                              |             |
| 7                   | hin 72<br>in "na<br>Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Completed        | (Specify only highest gr<br>Elementary/Secondary (0-12)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ade completed)  College (1-4or 5+                | life.                               | kind of work done<br>DO NOT use retire                         | during most of world)                     | rking                               |                   | imore                       |                                      |             |
| 7                   | d with<br>giene<br>er tha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | E                | 11th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 55.15 <b>3</b> 5 (1.151. <b>5</b> )              | <u> </u>                            | Superv                                                         | isor                                      |                                     | 0                 | of Educ                     | ation                                |             |
| 2                   | se file                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Be (             | 17. Father's Name (First, Middle, Las                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ")                                               |                                     |                                                                |                                           | me (First, Middle,                  | Maiden Su         | ırname)                     |                                      |             |
| <u>×</u>            | should be fand Mental Is marked of umatic eve                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2                | Benjamin A. Byrd                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  |                                     |                                                                | Minnie                                    |                                     |                   |                             |                                      |             |
| Maryland            | 12 sh<br>h and<br>is m                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ĺ                | 19a. Informant's Name/Relationship                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ,                                                |                                     |                                                                | t and Number or Ri                        |                                     |                   |                             |                                      | 21 200      |
|                     | 1 and<br>Health                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | Hilda O. Byrd/wif                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | e                                                | 20h Place of Diene                  | nsition /Name of                                               | rest Way,                                 | Apt. AS                             |                   | tion - City or              |                                      | 21200       |
| Baltimore,          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evemt, the Medical Examiner must be notified at once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Cont |                                                  | Druid Rid                           | matory or other pla<br>ge Cemete                               | ery 02/1                                  | 5/2008                              |                   | sville                      |                                      |             |
| Balt                | permit. Depart Import any inj                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 21. Signature of Funeral Service Lice                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Walton                                           |                                     | <sup>2. Name and Addre<br/><b>ewis N. V</b><br/>618 West</sup> | ess of Facility<br>Natson Fu<br>Rd., Sal  | neral Ho                            | ome<br>MD 21      | 801                         |                                      |             |
|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 23a. Part1. Enter the disease, or con shock, or heart failure. List only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | /                                                |                                     |                                                                |                                           |                                     |                   |                             | Approximate<br>Interval Bety         | e<br>ween   |
| W                   | Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | Immediate Cause (Final disease or condition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                  |                                     |                                                                |                                           |                                     |                   |                             | Onset and E                          | Death       |
| Ž.                  | /Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | resulting in death)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Due to (or as a                                  | consequence of):                    | -                                                              | _                                         |                                     |                   |                             | ,~                                   |             |
| ı.                  | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | Sequentially list conditions,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | a. hyperka<br>Due to (or as a<br>b. in the of    | perative c                          | graft re                                                       | pertus:                                   | ٥٦                                  |                   |                             | 5 Minu                               | tes         |
|                     | pe:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ine              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Due to (or as a                                  | consequence or).                    | 1 A 501                                                        | . 1 4                                     |                                     |                   |                             | 5 1.                                 |             |
|                     | xecur<br>and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Examiner         | that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | c. Due to (or as a                               | consequence of):                    | V 1244)                                                        | TIANT                                     |                                     |                   |                             | J NV                                 | <i>A</i> () |
| 68760,              | ficate be executed<br>physician and<br>is the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Live                                             | - failure                           |                                                                |                                           |                                     |                   |                             | 10 420                               | irs         |
|                     | tificat<br>g phy<br>as the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ledical          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                  |                                     |                                                                |                                           |                                     |                   |                             | i i                                  |             |
| Box                 | The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Physician/M      | IF FEMALE:<br>23b. Was decedent pregnant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 23c. If yes, outcome p                           |                                     | ⊒Ectopic pregnanc                                              | ev                                        |                                     | 230               | d. Date of deli             |                                      | /aa.        |
| Н                   | e dea<br>the att                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | sici             | in the past 12 months? 1 ☐ Yes 2 ☐ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4□Pregnant at t<br>9□Unknown                     |                                     | Other (specify)                                                |                                           |                                     |                   | Month                       | Day Y                                | Year        |
| Vital Records, P.O. | d by t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Ph               | 9 ☐ Unknown  Part II. Other significant conditions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | contributing to death but                        | t not reculting in the u            | ındarlırina causa ai                                           | von in Part I                             | 23e Did t                           | obacco use        | contribute to               | the cause of d                       | Leath?      |
| Ś                   | ires that<br>signed t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | by               | diabetes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | contributing to death but                        | thot readining in the c             | indenying eddae gi                                             | VOITINT CITY.                             | 1 🗆                                 | \ \               |                             | obably 4 □L                          |             |
| Ö                   | w require<br>been sign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Completed        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                  |                                     |                                                                |                                           | 24a. Was                            |                   |                             | toney findings                       | available   |
| æ                   | ne lav<br>e has<br>ge 2 g                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ldm              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                  |                                     |                                                                |                                           | auto                                | osy<br>ormed2     | prior to death?             | topsy findings a<br>completion of ca | ause of     |
| ā                   | in: T<br>ificate<br>or, pa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  | 25. Was case referred to medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  |                                     |                                                                | 26 Place of Do                            | 1 Yes<br>ath (Check only o          | 2 No              | 1 □ Yes                     | 2 No                                 |             |
| >                   | <b>hysician:</b> The law<br>his certificate has t<br>I director, page 2 s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | To Be            | examiner?<br>1 X Yes 2 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Hospital:                                        | t 2 ☐ ER/Outpatie                   | nt 3 DOA Ot                                                    | hor:                                      | dun ( <i>Check only</i> C           |                   | Other (Spec                 | eifv)                                |             |
| ō                   | ding Phys<br>h.<br>: After this<br>funeral di                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 27. Manner of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 28a. Date of Injury<br>(Month, Day               | / 28b. Time o                       |                                                                |                                           | 28d. Describe                       |                   |                             | ,                                    |             |
| Ö                   | arth.<br>or: Aff                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | atio             | 1 XNatural 5 Pending investigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | n                                                | reary injery                        |                                                                | ]Yes 2 □ No                               |                                     |                   |                             |                                      |             |
| Division or         | l or Attend<br>after death<br>Director:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Certification:   | 3 ☐ Suicide 6 ☐ Could not to determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                  | ry - At home, farm, st<br>(Specify) | reet, factory, office                                          |                                           | 28f. Location (<br>City or To       |                   | Number or Ru                | ral Route Num                        | ber,        |
|                     | purs a constant leeral L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | 29a. Certifier 1 Certifying P                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | hysician: To the best o                          | f my knowledge, deat                | th occurred at the t                                           | ime, date and plac                        | e. and due to the                   | cause(s) ar       | nd manner as                | stated.                              |             |
|                     | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Medical          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | miner: On the basis of<br>and manner stat        | examination and/or in               |                                                                |                                           |                                     |                   |                             |                                      | i)          |
|                     | To the To the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the Congression of the | M                | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                  |                                     | 29c. Licen                                                     |                                           |                                     | 29d. Date s       | signed (Monti               | n, Day, Year)                        |             |
|                     | les:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ~                                                | MO                                  | RES                                                            | 5-000                                     |                                     | 02/               | 10/20                       | 08                                   |             |
|                     | 10 M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 30. Name and address of person who                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | completed cause of de                            | ath (Item 23a) (Type,               | Print)                                                         | stroet                                    | R 11-1                              | se 1              | hac la                      |                                      |             |
|                     | Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | te               | 31. Date filed (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2008 32 Projected                                | r's Signature                       | 1. N.                                                          | 1                                         | DALLIM                              | 7                 | 100 9 10                    | - 1                                  |             |
|                     | Registr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ar               | FEB 14                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ZUUO                                             | in So of                            |                                                                |                                           |                                     |                   |                             |                                      |             |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1- State Amended 26 per phys, DOR, 2/19/08 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Bailey 7:10P M Mes 2008 eb. 12 /Medical 10 4a. Facility Name (If not institution, give street and number) 48. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Se Easton talbot If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Min 88 0.1919 Maryland Director Oct. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Laston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Street 2160 USA permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" any injury or other transmitted. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Very 2 No 1946 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify. ģ 3 Widowed 4 □ Divorced Black 1949 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Someone ter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( EMMa Brooks harles ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Street Easton, Mary land 21601
te 20c. Location - City or Town, State 20a. Method of Disposition 610 August 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State 2/20/08 Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland Veterans 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smooth, or heart failure. List only one cause on each line. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MD. 21613 Approximate Interval Between Onset and Death Immediate Cause (Final Cancer **Physician** ONR Year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed buriat-transi attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) Yes 2 ☐ No the 9☐Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 2 No 1 Yes Completed Pme 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autonsy performed? 1 Yes 2 No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify esidence Hospital: 1 ☐ Yes 2 No မှ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c 1 icense number 29d. Date signed (Month, Day, Year) Physician D005 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Tuhammaa

31. Date filed (Month, Day, Year)

FEB 1

DHMH 17 Rev 1/2001

830

32. Registrar's Signature

|                |                                                                                                                                                                                                                                                     |                  |                                                                     | Please                                   | Type or Prin                                       | t in Bla       | ack Ind               | delible Ink                            | . Ensure A                             | II Copies                                 | Are Leg                       | jible.                        |                                                    |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------|------------------------------------------|----------------------------------------------------|----------------|-----------------------|----------------------------------------|----------------------------------------|-------------------------------------------|-------------------------------|-------------------------------|----------------------------------------------------|
|                | State of Maryland / Department of Health and Mental Hygiene Certificate of Death                                                                                                                                                                    |                  |                                                                     |                                          |                                                    |                |                       |                                        |                                        |                                           |                               |                               |                                                    |
|                |                                                                                                                                                                                                                                                     | ye.              | Registrar                                                           | o (First Middle Le                       | agt)                                               |                | Cer                   | tificate of                            | Death                                  | 2. Date of Dea                            | Reg. No.                      |                               | 3. Time of Death                                   |
|                | Physicia                                                                                                                                                                                                                                            |                  | Decedent's Name  Junior                                             | e (riist, iviidale, La                   | Edward                                             | Cr             | awfor                 | d                                      |                                        | Month<br>FEBRUAR                          | Day                           | Year 2008                     | 1:57 A M                                           |
|                | /Medic<br>Examin                                                                                                                                                                                                                                    | 45.42            |                                                                     | f not institution, giv                   | ve street and number)                              |                | awioi                 |                                        | or Location of Death                   |                                           |                               | ty of Deat                    |                                                    |
|                |                                                                                                                                                                                                                                                     |                  | MEMORIAL                                                            | HOSPITAL                                 |                                                    |                |                       | CUMBE                                  |                                        |                                           | A                             | LLEGA                         |                                                    |
|                | Funeral<br>Director                                                                                                                                                                                                                                 |                  | 5. Social Security N                                                |                                          | Sex 7. Age                                         | (In yrs. las   | t birthday)<br>Yrs.   | If Under 1 Year<br>Months Days         | If Under 24 Hrs.<br>Hours Min.         | 8. Date of Birth<br>(Month, Day<br>Jan 23 | Year)                         | 9. Birtl                      | hplace (State or Foreign<br>untry)<br>MD           |
| 30.            |                                                                                                                                                                                                                                                     |                  | 214-42-(<br>Usual Residence of                                      | J405                                     | X                                                  | 64             |                       |                                        |                                        | Jan 20                                    | , 1044                        |                               |                                                    |
|                | hours after death with the Maryland<br>tural", or Items 23a or 28a-f show<br>al Examiner must be notified at                                                                                                                                        |                  | 10a. State                                                          | 10b. County                              | any                                                | 10c. City, T   |                       | ation<br>berland                       |                                        |                                           |                               |                               | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No             |
|                | he Ma<br>8a-f s                                                                                                                                                                                                                                     | Director         | MD                                                                  | Alleg                                    | ally                                               |                | Cuit                  | 10f. Zip Code                          |                                        |                                           | 10g. Citizen c                | f What Co                     | ^                                                  |
|                | with t                                                                                                                                                                                                                                              | į                | 10e. Street and Nur                                                 | tella Stre                               | at                                                 |                |                       | Tot. Zip Code                          | 21502                                  |                                           | rog. Onizon c                 | USA                           | unay.                                              |
|                | death<br>ms 23                                                                                                                                                                                                                                      | Funeral          | 11. Marital Status                                                  | tella Stiet                              | 12. Was Decedent B                                 | Ever in U.S.   | 13. V                 | Vas Decedent of I                      | Hispanic Origin? (Span, Mexican, Puert | pecify Yes or No-                         | 14. R                         |                               | rican Indian,                                      |
| ٥              | after<br>or ite                                                                                                                                                                                                                                     | Fu               | _                                                                   | ied 2 Married                            | Armed Forces?<br>1 ☐ Yes 2 🕱 N<br>If Yes, Give     | 10             |                       | ☐ Yes 2☐ <b>X</b> o                    |                                        | o nican, etc.)                            | Spec                          |                               |                                                    |
| 200            | nours<br>ural",                                                                                                                                                                                                                                     | d by             | 3 Widowed                                                           |                                          | Year or Dates:                                     |                |                       | ent's Usual Occu                       |                                        |                                           | 16b. Kind of                  | · W                           | hite                                               |
| 9500-91212     | be filed within 72 hours after death with the Marylar that Hygiene. And Hygiene. And Hygiene. And other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Completed        |                                                                     | 15. Decedent's E<br>cify only highest gr | ade completed)                                     |                | (Give life. E         | kind of work done<br>OO NOT use retire | e during most of wor<br>ed)            | king                                      | 16b. Killa of                 | Dusilless/                    | industry                                           |
| 7<br>7         | filed within 72<br>Hygiene.<br>other than "na<br>ent, the Medic                                                                                                                                                                                     | шо               | Elementary/Seco                                                     | 12                                       | College (1-4or 5                                   |                | mech                  | anic                                   |                                        |                                           | Penn                          | Mar I                         | Motors                                             |
| D              | be filed<br>stal Hyg<br>sd othe<br>event,                                                                                                                                                                                                           | Be C             | 17. Father's Name                                                   |                                          |                                                    |                |                       |                                        | 18. Mother's Nan                       |                                           |                               |                               |                                                    |
| <u>a</u>       | ould b<br>Ment<br>arkec<br>arlic e                                                                                                                                                                                                                  | 2                |                                                                     | les Craw                                 |                                                    | T              |                       |                                        | Anna                                   | (Grady)                                   |                               |                               |                                                    |
| Maryland       | permit. Pages 1 and 2 should be<br>Department of Health and Menta<br>Important: If item 27 is marked<br>any injury or other traumatic ev                                                                                                            |                  | 19a. Informant's Na                                                 | <sub>ame/Relationship</sub><br>s Crawfor |                                                    |                |                       | g Address (Stree<br>B Estella          | t and Number or Ru<br>Street           |                                           | nberlan                       |                               | MD 21502                                           |
| ā,             | s 1 an<br>f Heal<br>item 2                                                                                                                                                                                                                          |                  | 20a. Method of Disp                                                 |                                          |                                                    | 20b. Plac      | ce of Dispos          | sition (Name of<br>natory or other pla | ace)                                   | Date                                      | 20c. Location                 | n - City or                   | Town, State                                        |
| Ē              | Page<br>nent o<br>int: If                                                                                                                                                                                                                           |                  |                                                                     | ☐ Cremation 3 [<br>5 ☐ Other (Spec       | Removal from State                                 |                |                       | emorial Ga                             |                                        | 2/28/2008                                 | LaVa                          | ale                           | MD                                                 |
| Baitimore,     | permit. Departn Importa any inju                                                                                                                                                                                                                    |                  | 21. Signature of Fu                                                 | neral Service Lice                       | ersee .                                            |                | 22                    | . Name and Addr<br>Scarpe              | ess of Facility<br>elli Funeral Ho     | ome, PA                                   |                               |                               |                                                    |
| 10             | 80 F 8 9                                                                                                                                                                                                                                            |                  | 1/1/6                                                               | UU///                                    |                                                    |                |                       | 108 Vi                                 | rginia Avenue                          | e: Cumberla                               |                               | 1502                          | Annavimata                                         |
|                |                                                                                                                                                                                                                                                     |                  | shock, or hea                                                       |                                          | nplications that caused<br>y one cause on each lin |                |                       |                                        |                                        |                                           | rest,                         |                               | Approximate<br>Interval Between<br>Onset and Death |
|                | Physician<br>/Medical                                                                                                                                                                                                                               |                  | disease or condition resulting in death)                            | on a                                     | a. Acute Due to (or as                             |                |                       | 2ATORY                                 | FAIL                                   | ile.                                      |                               |                               | 1 Day                                              |
|                | Examiner                                                                                                                                                                                                                                            |                  |                                                                     |                                          | PREUM                                              |                | 100 01).              |                                        |                                        |                                           |                               |                               | IDAY                                               |
| , in           |                                                                                                                                                                                                                                                     | ner              | Sequentially list co<br>if any, leading to in<br>cause. Enter Under | onditions,<br>nmediate<br>erlying        | Due to (or as                                      |                | nce of):              |                                        |                                        |                                           |                               |                               |                                                    |
|                | e executed<br>ian and<br>urial-transit                                                                                                                                                                                                              | Examiner         | Cause (Disease or<br>that initiated events<br>resulting in death) I | injury                                   | c<br>Due to (or as                                 | 2 000000000    | nce of):              |                                        |                                        |                                           |                               |                               |                                                    |
| 50,            | be ex<br>ician<br>burial                                                                                                                                                                                                                            | -                | , , , , , , , , , , , , , , , , , , , ,                             | l                                        |                                                    | a conseque     | nice or).             |                                        |                                        |                                           |                               |                               |                                                    |
| 68/60,         | death certificate be<br>attending physicia<br>I for use as the bur                                                                                                                                                                                  | edic             |                                                                     |                                          | d                                                  |                |                       |                                        |                                        |                                           |                               |                               |                                                    |
| X<br>Q<br>Q    | h certi<br>anding<br>use a                                                                                                                                                                                                                          | M/u              | IF FEMALE:<br>23b. Was deceden                                      |                                          | 23c. If yes, outcome<br>1 ☐ Live birth             |                |                       | Ectopic pregnan                        | CV                                     |                                           |                               | Date of del                   |                                                    |
|                | The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit                                                                                    | Physician/Medica | in the past 12<br>1 ☐ Yes 2 [                                       | □No                                      | 4□Pregnant at                                      |                |                       | Other (specify)                        |                                        |                                           |                               | Month                         | Day Year                                           |
| r<br>Ö         | that the de<br>ned by the a<br>detached to                                                                                                                                                                                                          | Phy              | 9 Unknown                                                           |                                          | contributing to death b                            | ut not resulti | ng in the ur          | nderlying cause o                      | iven in Part I                         | 23e. Did t                                | phacco use c                  | ontribute to                  | the cause of death?                                |
| Vital Records, | signe<br>d be d                                                                                                                                                                                                                                     | d by             | CORONA                                                              |                                          | ecery t                                            |                |                       | racity in ground or g                  |                                        | 1 🗙                                       | -                             |                               | robably 4 □Unknown                                 |
| Ö              | w requires<br>been signe<br>should be                                                                                                                                                                                                               | lete             | CHRON                                                               |                                          | CROCCIVE                                           |                |                       | 17000                                  | DECAS                                  | 24a. Was                                  | an 24                         | b. Were au                    | utopsy findings available                          |
| Ž              | <b>sIclan</b> : The law<br>certificate has b<br>irector, page 2 s                                                                                                                                                                                   | Completed by     | CARRON                                                              | AC CIBS                                  | CACC (IVE                                          | 110            |                       | CHEY                                   | 3640                                   | autoj<br>perfo<br>1□ Yes                  | osy<br>rmed?<br>2 <b>X</b> No | prior to<br>death?<br>1 ☐ Yes | completion of cause of<br>2 □ No                   |
| <u>a</u>       |                                                                                                                                                                                                                                                     | Be C             | 25. Was case referexaminer?                                         | rred to medical                          |                                                    |                |                       |                                        | 26. Place of Dea                       | ath (Check only o                         |                               |                               |                                                    |
| o<br>_         | Physic<br>this ce<br>al direc                                                                                                                                                                                                                       | ToE              | 1 ☐ Yes 2⁄2                                                         |                                          | Hospital: 1 Inpatie                                |                |                       | I 3 DOA                                |                                        | Home 5 ☐ Resi                             |                               |                               | cify)                                              |
| ב              | ding Pt<br>h.<br>After th<br>funeral                                                                                                                                                                                                                |                  | 27. Manner of Deat<br>1 Natural                                     | 5 Pending                                | 28a. Date of Inju<br>(Month, Da                    |                | 8b. Time of<br>Injury | Wo                                     | uryat<br>ork?<br>⊒Yes 2 ⊒No            | 28d. Describe                             | now injury occ                | curred                        |                                                    |
| DIVISION       | Attend<br>death.<br>ector: /<br>y the fi                                                                                                                                                                                                            | icat             | 2 ☐ Accident<br>3 ☐ Suicide                                         | investigation 6 □ Could not lidetermine  | be 290 Place of init                               | ury - At hom   | e, farm, str          | eet, factory, office                   |                                        | 28f. Location (                           | Street and Nu                 | mber or R                     | ural Route Number,                                 |
| 2              | al or A<br>s after<br>al Dire                                                                                                                                                                                                                       | Certification:   | 4 ☐ Homicide                                                        | determine                                | building, et                                       | c. (Specify)   |                       |                                        |                                        | City or To                                | vn, State)                    |                               |                                                    |
|                | To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director. After this certific completely filled in by the funeral director,                                                                                     |                  | 29a. Certifier<br>(Check only                                       |                                          | Physician: To the best                             |                |                       |                                        |                                        |                                           |                               |                               |                                                    |
|                | To the H<br>within 24<br>To the F<br>complete                                                                                                                                                                                                       | Medical          | one) 29b. Signature and                                             | DA                                       | and manner sta                                     |                |                       |                                        | nse number                             |                                           |                               |                               | th, Day, Year)                                     |
|                | <b>5</b>                                                                                                                                                                                                                                            |                  | 29b. Signature and                                                  | Ittle of certifie                        | hame                                               |                |                       |                                        | 033280                                 |                                           | feb 2                         |                               |                                                    |
| 1              |                                                                                                                                                                                                                                                     |                  | 30. Name and add                                                    | ress of person value                     | o completed cause of d                             | eath (Item 2   | 3a) (Type.            |                                        |                                        |                                           |                               | ,                             | BEEL AND, MD                                       |
|                |                                                                                                                                                                                                                                                     |                  | 0 /                                                                 | GUPTA.                                   | M.D. ck                                            | THNSC          | on t                  |                                        | MEDICA                                 | - BOILT                                   | DUK                           |                               | 21502                                              |
|                | Sta                                                                                                                                                                                                                                                 |                  | 31. Date filed (Mor                                                 |                                          | 32. Registr                                        | ar's Signatu   | re                    | forts)                                 |                                        |                                           |                               |                               |                                                    |
|                | Registi                                                                                                                                                                                                                                             | ar               |                                                                     | man U                                    | 0 2000                                             | Albert Col     | 30                    |                                        |                                        |                                           |                               |                               |                                                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:03 PM Februaru 11 2008 GERTRUDE CONEY FRANCES 4a. Facility Name (If not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death PRINCE GEORGE'S DOCTORS HOSPITAL LANHAM 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/28/1923 Birthplace (State or Foreign
Country) 7. Age (In vrs. last hirthday) 6 Sex Davs 1 □ M 2 1 F 578-38-4740 84 BETHESĎA, MD Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1/2Yes 2 No MD PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3850 ENFIELD CHASE CT. 20715 BLACK 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 🏖 No Specify Specify: 3 Widowed 4 Divorced Year or Dates: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH GOV T EMPLOYMENT OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM L. HEBRON VIRGINIA BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) INGRID CONEY/DAUGHTER 13000 CLOVERLY DR. UPPER MARLBORO, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) D VETERANS 2/27/2008 CHELTENHAM, 22. Name and Address of Facility J. D. JENKINS MARYLAND VETERANS 21. Signatur, of Foreral St Mich 474 LANDOVER RD. LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EPSIC Due to (or as a consequence of) SMAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2₽No 3 Probably 4 Unknown VENOUS TROMBOSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No REPLACEMENT 24a. Was an 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√10 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural

Examiner Division or Vital Records, P.O. Box 68760, for

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.

Baltimore, Maryland

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical in once.

Physician /Medical Director

by Funeral

Completed

Be

Examiner

Physician/Medical

ğ

Completed

Be

Certification:

23b. Was decedent pregnant

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

6 ☐ Could not be

2 Accident

3 Suicide

29a. Certifier

4 THomicide

29c. License number D0050951 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KENILWORTH AVE, SUITE 2400 RIVERDALE MD 20737 6510 31. Date filed (Month, Day, Year)

Registrar

FEB 1 9 2008



and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hours a

To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [ Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Year 4:35 PM 2008 /Medical Georgia Lee Clark 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospi Year I If Under 24 Hrs. licomico ce at the 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 75 Months Days Hours Director 220-28-0362 09-04-1932 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notifled at 1 ☐ Yes 2 No Director Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30558 Bardwell Drive 21853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Completed by 3 ☐ Widowed 4 ☑ Divorced White Baltimore, Maryland 21215-0 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) other traumatic event, the Seamstress Clothing permit. Pages 1 and 2 should be file Department of Health and Mental Hy Imporant: if item 27 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hoyt Somers ို Barbara Laird 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Mansfield/son 9009 Galena Drive, El Paso, Texas 79904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Rurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Beechwood Cemetery 2/16/2008 Princess Anne, MD Signature of Fun Service Licensee 22 Name and Address of Facility. Hinman Funeral Home 11673 Somerset Ave., Princess Anne, M00295 MD 21853 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Physician Ubstru /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 □Unknown page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has Physiclan: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Medical Certification: To 1 mpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mapner Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation Hospital or Attending Injury 1 ☐ Yes 2 ☐ No I hours after death. death. 2 Accident To u.c.
Within 24 hours ...
To the Funeral Directo... 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number Signatore and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

19 FEB 2008

31. Date filed (Month, Day, Year)

nistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oastal

ourl, M)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Casalena Feb. 11 2008 11:30a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Village Health Care Ctr. Montgomery Village Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2**√**F 85 Director 220-38-7521 Sept 8, 1922 Italy Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Director Oueen Annes Stevensville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 332 North Lake Road 21666 Funeral USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No white Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) clothing 8 seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill finent of Health and Mental Hant: If Item 27 Is marked oth Jury or other traumatic even Be Nina Noto Salvatore ဂ Spinato 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2072 Misty Meadow Road, Finksburg, Md. 21048 Elio Casalena 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 15, injury or permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Woodlawn, MD. 2008 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licens M01072 934 S. Main St., Hampstead, Md. 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cerebrovascular accident /Medical Due to (or as a consequence of) Examiner Azotemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed Hypernatremia burial-tra Due to (or as a consequence of) physician Physician/Medical Clostridium difficile colitis the IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a Was an certificate 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 XNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Pruneral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Feb. 11, 2008 D41162 WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Vinu Ganti, M.D., 19529 Doctor's Drive, Germantown, MD. 20874

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

FEB 15

2008

Saltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

32. Registrar's Signature Elegen

|                   |                                                                                                                                                                          | •              | 1 - State of Maryland / Department of Registrar Cert                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | rtificate of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ientai mygien<br>Reg. N                      | 2000                         | 06404                                              |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|------------------------------|----------------------------------------------------|
|                   | Physici                                                                                                                                                                  |                | 1. Decedent's Name (First, Middle, Last)  Dorothy L. Childress                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2. Date of Death Month Di February           | ay Year 9, 2008              | 3. Time of Death 2:30 P M                          |
| 1                 | /Medio                                                                                                                                                                   |                | 4a. Facility Name (If not institution, give street and number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4b. City, Town, or Location of Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1 ebruary                                    | c. County of Death           | 2.30 1                                             |
|                   | Exami                                                                                                                                                                    |                | 10704 Westwood Lane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Waldorf                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              | Char                         | les                                                |
|                   | Funeral                                                                                                                                                                  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8. Date of Birth<br>(Month, Day, Year        | 9. Birthpl                   | ace (State or Foreign                              |
| ы                 | Director                                                                                                                                                                 |                | 577-16-8734 1□ M 2♥ F 86 Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Sept. 15,                                    | 1921 Wash                    | ington D.C.                                        |
|                   | and w                                                                                                                                                                    |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ocation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              | 10                           | Od. Inside City Limits                             |
|                   | /anyla                                                                                                                                                                   | ō              | Maryland Charles                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Waldorf                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              |                              | 1 □ Yes 2 <b>X</b> □ No                            |
|                   | the 28a-                                                                                                                                                                 | Director       | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10f. Zip Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 10g. C                                       | itizen of What Coun          | try?                                               |
|                   | 3a or                                                                                                                                                                    | Ö              | 10704 Westwood Lane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 20601                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                              | U.S.A                        |                                                    |
|                   | ms 2                                                                                                                                                                     | Funeral        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Was Decedent of Hispanic Origin? (Spe<br>If Yes, specify Cuban, Mexican, Puerto                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ecify Yes or No-                             | 14. Race - America           | an Indian,                                         |
| 21215-0036        | be filed within 72 hours after death with the Maryland that Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | þ              | 1 Never Married 2 Married 1 Yes 2 V No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1 ☐ Yes 2 No Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | nican, etc.)                                 | Black, White, e              | ite                                                |
| 2-0               | 72 ho<br>natur<br>fical                                                                                                                                                  | Completed      | 15. Decedent's Education 16a. Dece<br>(Specify only highest grade completed) (Give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | dent's Usual Occupation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ina i                                        | Kind of Business/Ind         |                                                    |
| 2                 | ithin he.                                                                                                                                                                | g              | Elementary/Secondary (0-12)   College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | kind of work done during most of worki<br>DO NOT use retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1                                            | ns Departi                   | ment                                               |
|                   | filed w<br>Hygier<br>other the                                                                                                                                           |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ft Wrapper                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (First, Middle, Maide                        | ore                          |                                                    |
| and               |                                                                                                                                                                          | Be             | 17. Father's Name ( <i>First, Middle, Last</i> )  Milton P. Knight                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              | ,                            |                                                    |
| ž                 | 2 should be f<br>n and Mental H<br>is marked of<br>raumatic ever                                                                                                         | ျှ             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ng Address (Street and Number or Rura                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | . Mattingl                                   |                              | Code) 017FC                                        |
| Maryland          | s 1 and 2 should<br>of Health and Mer<br>Item 27 is marke<br>other traumatic                                                                                             |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 32 Manisfield Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                              |                              |                                                    |
|                   | Health<br>tem 27<br>tem 27                                                                                                                                               |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              | Location - City or To        | <u> </u>                                           |
| Baltimore,        | Pages<br>ment of<br>ant: If I<br>ury or                                                                                                                                  |                | I Mibunal Z Licremation at Internoval from State 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Memorial Gdns 2/15                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | /2008 V                                      | Waldorf, M                   | aryland                                            |
| Balt              | permit. Pages 'Department of H<br>Important: If Ite<br>any Injury or of<br>once.                                                                                         |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 2. Name and Address of Facility untt Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                              | Washingto<br>Maryland,       |                                                    |
|                   | STAIL.                                                                                                                                                                   |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ter the mode of dying, such as cardiac                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | or respiratory arrest,                       |                              | Approximate<br>Interval Between<br>Onset and Death |
| 200               | Physician                                                                                                                                                                |                | Immediate Cause (Final disease or condition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | OMA OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | LUNG                                         | 3                            | Onset and Death                                    |
| pir:              | /Medical<br>Examiner                                                                                                                                                     |                | resulting in death)  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              |                              |                                                    |
|                   | Examine                                                                                                                                                                  | _              | Sequentially list conditions, b.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              |                              |                                                    |
|                   | ped Isit                                                                                                                                                                 | nine           | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              |                              |                                                    |
|                   | and al-trar                                                                                                                                                              | Examiner       | that initiated events c.  resulting in death) Last Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              |                              |                                                    |
| 68760,            | tificate be executed<br>g physician and<br>as the burial-transit                                                                                                         | E E            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              |                              |                                                    |
| .89               | tificate<br>g phy<br>as the                                                                                                                                              | edical         | U.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              |                              |                                                    |
| Box               | ath cer<br>attendin<br>for use                                                                                                                                           | Physician/M    | 1 Yes 2 No 4 Pregnant at time of death 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | □Ectopic pregnancy<br>□ Other (specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              | 23d. Date of delive<br>Month | ry<br>Day Year                                     |
| P.0               | that the de<br>led by the a<br>detached                                                                                                                                  | Phy            | 9 Li Onknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | and a file and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second a second and cond and cond and a second and a second and a | OO - Did tob                                 | use contribute to the        |                                                    |
|                   | w requires that<br>been signed<br>should be det                                                                                                                          | þ              | Part II. Other significant conditions contributing to death but not resulting in the u                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | inderlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1 ☐ Yes                                      |                              |                                                    |
| or Vital Records, | The law recate has be page 2 sho                                                                                                                                         | Completed      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ***                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 24a. Was an autopsy performed? 1  Yes 2      | death?                       | psy findings available<br>npletion of cause of     |
| ta                |                                                                                                                                                                          | 0              | 25. Was case referred to medical examiner?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 26. Place of Deat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | h (Check only one)                           |                              |                                                    |
| >                 | di is                                                                                                                                                                    | To B           | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | me 5 Residence                               | 6 □Other (Specif)            | 1)                                                 |
| ū                 | ding Pt                                                                                                                                                                  |                | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury Injury 17 (Month, Day Year) 17 (Month, Day Year) 18 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury 19 (Injury | Work?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 28d. Describe how in                         | jury occurred                |                                                    |
| sio               | Attending r death. ector: After y the fune                                                                                                                               | cati           | 2 Accident investigation 3 Suicide 6 Could not be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | M 1 Yes 2 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                              |                              |                                                    |
| Division          | after c<br>Dlrec                                                                                                                                                         | Certification: | 4 ☐ Homicide determined determined 28e. Place of injury - At home, farm, st building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | reet, factory, office                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 28f. Location (Street a<br>City or Town, Sta |                              | i Houte Number,                                    |
|                   | To the Hospital or Attenc<br>within 24 hours after death<br>To the Funeral Director:<br>completely filled in by the                                                      | Medical C      | 29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, deat of the basis of examination and/or in and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              |                              |                                                    |
|                   | To the within To the Compl                                                                                                                                               | Me             | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 29c. License number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 29d. E                                       | Date signed (Month,          | Day, Year)                                         |
|                   |                                                                                                                                                                          |                | Myemlam wo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | D 2899                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 79 =                                         | 2/14/-                       | 2008                                               |
| P                 | B10                                                                                                                                                                      |                | po. Name and address of person was completed cause of death (item 23a) (Type,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 9131 DISCATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | AWAY RO                                      | CLI                          | with My                                            |
| ľ                 | Sta<br>Registi                                                                                                                                                           |                | 31. Date filed (Month, Day, Year)  FEB 1 5 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | de la                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                              |                              |                                                    |

State of Maryland / Department of Health and Mental Hygiene State RegistraMEND#20boerFH2/15/08, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** VANESSA DANESE COLEMAN FEB 2008 12:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1435 SOUTHERN AVE. #102 OXON HILL PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2X F 47 Director 578-84-3263 OCT. 16,1960 WASH. D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 ☐ No Director PRINCE GEORGES OXON HILL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1435 SOUTHERN AVE. #102 U.S.A. 20745 Completed by Funeral death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant; If Item 27 Is marked other than "natural", or Iter ury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ▼No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 X Divorced BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BAKER GIANT FOOD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ **JAMES** COLEMAN MAGALEANE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) COLEMAN/SISTER CURTIS DR. APT. 604, SUITLAND, MD. 20746 JAMIE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date HNIZ 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any injury or CHAMBERS CREMATORY Feb. 15,2008 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility HOME & CREMATORIUM, P. A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC ARREST /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or) The law requires that the death certificate be executed burial-transi HYPERTENSION Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical DIABETES MELLITUS the IF FEMALE use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💢 No for Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign be ( 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1□ Yes 2☑ No or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral ( 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Natural 2 Accident 1 □ Yes 2 □ No ours after death.
neral Director; A
filled in by the fu 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Karate of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signatur e and title of certifier 29c. License number erson who completed cause of death (Item 23a) (Type, Print) SMITH, 1328 SOUTHERN AVE., S.E., WASHINGTON, D.C. 20032 BARRY LEE M.D. 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State FEB 14 2008 Registrar

DHMH 17 Rev 1/2001

|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 1 - State<br>Registrar                                                                                                                           |                                                                                            | Cei                                   | tificate of                                                            | Death                                           |                                            | Reg. No                 | 2000                                                | 00400                                              |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------|------------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------|-------------------------|-----------------------------------------------------|----------------------------------------------------|
| H           | Physicia<br>/Medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | Decedent's Name (First, Middle, Last)     VIRGINIA                                                                                               | CRAIG                                                                                      |                                       |                                                                        |                                                 | 2. Date of D<br>Month<br>2                 | eath<br>1 <sup>Da</sup> | 2008                                                | 3. Time of Death<br>7.54 Am                        |
|             | Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | er                      | 4a. Facility Name (If not institution, give s. 5500 LINCOLN AVE.                                                                                 |                                                                                            |                                       |                                                                        | NHAM                                            |                                            |                         | RINCE GE(                                           | ORGE'S                                             |
|             | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 373 30 3071                                                                                                                                      | 7. Age (In yrs. 1                                                                          | ast birthday)<br>Yrs.                 | If Under 1 Year<br>Months Days                                         | If Under 24 Hi<br>Hours Mi                      |                                            | 1931                    | 9. Birthp                                           | lace (State or Foreign                             |
|             | e Maryland<br>3a-f show<br>tified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ctor                    | Usual Residence of Decedent  10a. State 10b. County  MD PRINCE GE                                                                                |                                                                                            | , Town or Lo                          | cation<br>LANHA                                                        | M                                               |                                            |                         | 1                                                   | 0d. Inside City Limits                             |
|             | th with th<br>23a or 26<br>ist be no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>Funeral Director</b> | 10e. Street and Number 5500 LINCOLN AVE                                                                                                          |                                                                                            |                                       | 10f. Zip Code                                                          | 0706                                            |                                            | _                       | tizen of What Cour<br>SA                            | ntry?                                              |
| 0000        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mertall Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medic al Examiner must be notified at once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | þ                       | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced                                                                               | 2. Was Decedent Ever in U.<br>Armed Forces?<br>1                                           |                                       | Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes XX No              | lispanic Origin?<br>an, Mexican, Pu<br>Specify: | (Specify Yes or Nerto Rican, etc.)         | 0-                      | 14. Race - Americ<br>Black, White,<br>Specify: BLAC | etc.                                               |
| N-C   7   7 | I within 72 ho<br>liene.<br>r <b>than "natu</b><br>th Medic I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Completed               | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)                                                                | cation<br>completed)<br>College (1-4or 5+)                                                 | (Give<br>life. i                      | dent's Usual Occup<br>kind of work done<br>DO NOT use retire<br>NALYST | oation<br>during most of w<br>d)                | vorking                                    |                         | GOVERNMEN                                           | ,                                                  |
| ומנומ       | uld be filed<br>Jental Hyg<br>rked other<br>tic event, i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | To Be C                 | 17. Father's Name (First, Middle, Last) WALTER K. KING                                                                                           |                                                                                            |                                       |                                                                        |                                                 | lame (First, Middle<br>ENCE THO            |                         | n Surname)                                          |                                                    |
| Mary        | ind 2 shou<br>alth and N<br>27 is mai<br>ir traumai                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 19a. Informant's Name/Relationship (Typ<br>ALOYSIUS C. CRAIG/                                                                                    | *                                                                                          |                                       | ng Address (Street                                                     |                                                 | Rural Route Num                            |                         | or Town, State, Zip                                 | Code)                                              |
| more,       | Pages 1 a<br>nent of Her<br>nt: If Item<br>iry or othe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)                                                     | .,                                                                                         | emetery, crei                         | sition (Name of<br>matory or other pla<br>CION CEME                    | TERY 2/                                         | Date<br>18/2008                            | l                       | ocation - City or To                                | own, State                                         |
| Dallillor   | permit. Departm Importa any inju                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 21. Signature of Funeral Service License                                                                                                         | aderiel                                                                                    | 74                                    | 2. Name and Addre                                                      | VER RD.                                         | · BLANDOV                                  | INS ER,                 | FUNERAL F<br>MD 20785                               | HOME                                               |
|             | Physician<br>/Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) | e cause on each line.                                                                      | EATIC                                 | er the mode of dyi                                                     |                                                 | liac or respiratory                        | arrest,                 |                                                     | Approximate<br>Interval Between<br>Onset and Death |
| į,          | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | iner                    | Sequentially list conditions, if any, leading to immediate cause. Et al Underlying                                                               | Due to (or as a consequ                                                                    | uence of):                            |                                                                        |                                                 |                                            |                         |                                                     |                                                    |
| ,00/00      | be execute<br>iician and<br>burial-tran                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | al Examiner             | Cause (Disease or injury that initiated events resulting in death) Last                                                                          | Due to (or as a consequ                                                                    | uence of):                            |                                                                        |                                                 |                                            |                         |                                                     |                                                    |
| O. BOX 001  | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Physician/Medical       | IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 ☑ No 9 □ Unknown                                                         | 3c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown | Ideath 3                              | ⊒Ectopic pregnanc<br>∃ Other (specify) _                               | у                                               |                                            |                         | 23d. Date of delive                                 | ery<br>Day Year                                    |
| rds, r.     | equires that the series of signed by the detaction of the detaction of the detaction of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series o | by                      | Part II. Other significant conditions con                                                                                                        | tributing to death but not resu                                                            | ulting in the u                       | nderlying cause giv                                                    | ven in Part I.                                  |                                            |                         | use contribute to t<br>2Î No 3 □ Prol               | he cause of death?                                 |
| al Records, | The law recate has been page 2 sho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Completed               |                                                                                                                                                  |                                                                                            |                                       |                                                                        |                                                 | 24a. Wa<br>aut<br>per<br>1  Yes            | opsy<br>formed?         | prior to co<br>death?                               | opsy findings available impletion of cause of      |
| N   [0]     | iclan<br>certifi<br>ector                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Be                      | 25. Was case referred to medical examiner?                                                                                                       | lospital:                                                                                  |                                       | Oth                                                                    | 10F'                                            | Death (Check only                          |                         |                                                     |                                                    |
| VISION OF   | nding Phys<br>th.<br>:: After this<br>e funeral dir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | tion: To                | 1  Yes 2                                                                                                                                         | 28a. Date of Injury<br>(Month, Day Year)                                                   | ER/Outpatier<br>28b. Time o<br>Injury | f 28c. Inju                                                            | 4 ☐ Nursing                                     | 28d. Describe                              |                         | 6 ☐Other (Special<br>ury occurred                   | (fy)                                               |
| DIVIS       | ial or Atters s after dea al Directored in by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Certification:          | 3 Suicide 6 Could not be determined                                                                                                              | 28e. Place of injury - At ho<br>building, etc. (Specif                                     | ome, farm, sti                        | reet, factory, office                                                  |                                                 | 28f. Location<br>City or T                 | (Street a<br>own, Stat  | and Number or Run<br>te)                            | al Route Number,                                   |
|             | he Hospi<br>n 24 hour<br>ne Funer:<br>pletely fille                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Medical (               | 29a. Certifier (Check only one)  1 ☑ Certifying Phys 2 ☐ Medical Examir                                                                          | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated.        | wledge, deat<br>tion and/or ir        | h occurred at the ti<br>vestigation, in my                             | me, date and pla<br>opinion, death o            | ace, and due to the<br>courred at the time | e cause(se, date ar     | s) and manner as s<br>nd place, and due t           | stated.<br>o the cause(s)                          |
| <b>)</b>    | To the within To the company                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | M¢                      | 29b. Signature and title of certifier  Bulyanness                                                                                                | in MO                                                                                      |                                       | 29c. Licens                                                            | se number<br>16619                              |                                            | 29d. D.                 | ate signed (Month,<br>BRUAPY                        | Day, Year) 16, 2008                                |
| 1           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 30. Name and address of person who co                                                                                                            | mpleted cause of death (Item<br>RES 99 40)                                                 | 1 23a) (Type,                         | Print) - S                                                             | quare                                           | Dr. Wi                                     | rik M                   | Yursh, M                                            | 10.21236                                           |

Registrar

31. Date filed (Month, Day, Year)
FEB 1 9 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Moses Louie Coe Feb. 14 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Southern MD Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) M 2 F 87 Yrs. 250-12-2644 Director 9-18-1920 SouthCarolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f st the Medical Examiner must be notifled 1 Yes 2 No Director MD Prince Georges Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3422 Keir Dr. 20746 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes &☐ No Specify: Black Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. ortant: if item 27 Is marked other than 'injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 2yr Police Officer Special Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Box 70658 Washington, DC 20024
Sition (Name of Date 20c. Location - City or Town, State Alecia Williams Wife P.O. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If i Cheseapeake 2/16/2008 Beltsville, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wesley Chavis III 10684 Southern MD Funeral Service PA BLVD Dunkirk,MD 20754 W. U 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed and Due to (or as a consequence of): physician a s the burial-1 Box 68760 Physician/Medical death certificate as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. ed by the a 9□Unknowr signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 2 🔀 No Division or Vital 2 X No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 2 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) Injury 1 Natural 5 Pending To the nusping within 24 hours after death.

To the Funeral Director: After the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the f investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) sonto Fall M.O. D43446 Feb. 15 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 9801 Georgia Are suit 3-41 (Suit) Silverspring MD 20902

DHMH 17 Rev 1/2001

State

Registrar

ROINTAN FARAHICAR

2008

31. Date filed (Month, Day, Year)

FEB 19

32. Registrar's Signatur

| te of Maryland / Department of Health and Mei | ntal Hygiene | 061.08 |
|-----------------------------------------------|--------------|--------|
| Certificate of Death                          | Reg No       | 00400  |
|                                               |              |        |

|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                                                                    | _                                                | Cer                                                          | tificate of                           | f Death                                        | ,                               | Reg. No.             | <i>)</i> ()                  | 00400                                    |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------|---------------------------------------|------------------------------------------------|---------------------------------|----------------------|------------------------------|------------------------------------------|
|                                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                 | 1. Decedent's Name (First, Middle, La                                              | nst)                                             |                                                              |                                       | -                                              | 2. Date of De                   | eath                 |                              | 3. Time of Death                         |
|                                | Physic<br>/Medi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 | James                                                                              | Chatman                                          |                                                              |                                       |                                                | Month<br>Februa                 | ary 12, 2            | Year<br>2008                 | 2:58 PM                                  |
| 1                              | Examir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | 4a. Fecility Name (If not institution, give                                        | re street and number)                            |                                                              |                                       | 4b. City, Town, or Lo                          |                                 |                      | of Death                     | 1                                        |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 | Mariner Health o                                                                   | f Bethesda                                       |                                                              |                                       | Bethesda                                       |                                 | Monts                | gomery                       | У                                        |
|                                | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                 | Social Security Number     6. 5                                                    | Sex 7. Age (In )                                 | vrs. last birthday)                                          | If Under 1 Yea                        |                                                | 8. Date of Bi                   | rth                  | 9. Birthp                    | elece (Stete or Foreign                  |
|                                | Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 8               | 250-28-6369                                                                        | 12M 2□ F 85                                      | Yrs.                                                         | Months Deys                           | s Hours Min.                                   | 04-24-                          | 1922                 | South                        | n Carolina                               |
|                                | P .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                 | Usual Residence of Decedent                                                        |                                                  |                                                              |                                       |                                                |                                 |                      |                              |                                          |
|                                | inylar<br>in how                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | _               | 10a. State 10b. County                                                             | 10c.                                             | City, Town or Loc                                            | cation                                |                                                |                                 |                      | 10                           | 0d. Inside City Limits                   |
|                                | Ba-f-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ဍ               | DC                                                                                 | W                                                | ashingto                                                     | n                                     |                                                |                                 |                      |                              | 1 No Yes 2 No                            |
|                                | # 2 ×                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Director        | 10e. Street and Number                                                             |                                                  |                                                              | 10f. Zip Code                         |                                                |                                 | 10g. Citizen of      | What Coun                    | try?                                     |
|                                | 23a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <u>a</u>        | 1234 Ingraham Sti                                                                  | ceet, NW                                         |                                                              | 20011                                 |                                                |                                 | USA                  |                              |                                          |
|                                | e ma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | by Funeral      | 11. Maritel Status                                                                 | 12. Was Decedent Ever in<br>Armed Forces?        | n U,S. 13. V                                                 | Vas Decedent of<br>Yes, specify Cu    | Hispanic Origin? (Sp.<br>ban, Mexican, Puerto  | ecify Yes or Ne<br>Rican, etc.) | 0- 14. Rad           | ce - America<br>ck, White, e |                                          |
| റ്റ                            | or it                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | F               | 1 Never Married 2 Married                                                          | 1 X Yes 2 No<br>If Yes, Give                     | 1942                                                         | ☐ Yes 2ŪXNo                           |                                                | ,                               | Specif               | · ·                          |                                          |
| 8                              | Jan.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Q P             | 3 X Widowed 4 □ Divorced                                                           | Year or Detes: †O                                | 1946                                                         |                                       |                                                |                                 |                      | ′ В                          | lack                                     |
| ξ                              | nath                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Completed       | 15. Decedent's E<br>(Specify only highest gro                                      | ducation<br>ade co <i>mpleted)</i>               | 16e. Deced<br>(Give I                                        | ent's Usual Occu<br>kind of work done | ipetion<br>e <i>during</i> most of work<br>ed) | ing                             | 16b. Kind of B       | usiness/Ind                  | iustry                                   |
| 12                             | vithir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Ē               | Elementary/Secondary (0-12)                                                        | College (1-4or 5+)                               |                                                              |                                       | pervisor                                       |                                 | Departs              | nant /                       | of Defense                               |
| 7                              | lled v<br>lygie<br>her t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ပိ              | 8th                                                                                |                                                  | Custo                                                        | outat su                              |                                                | (FT) . A FT ( 1)                | *                    |                              | JI Delense                               |
| ũ                              | tal H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Be              | 17. Father's Neme (First, Middle, Last                                             |                                                  |                                                              |                                       | 18. Mother's Name                              |                                 |                      | 1e)                          |                                          |
| ž                              | ould<br>Merke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ဥ               | Oscar Chatman                                                                      |                                                  |                                                              |                                       | Alma Mor                                       |                                 |                      |                              |                                          |
| ā                              | permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiner must be notified at once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                 | 19e. Informant's Name/Relationship (                                               |                                                  |                                                              |                                       | et and Number or Run                           |                                 | er, City or Town     | State, Zip                   |                                          |
| d)                             | end<br>lealth<br>m 27<br>her t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                 | Keith Chatman/Son                                                                  |                                                  |                                                              |                                       | m Street,                                      |                                 | shington             | <del></del>                  | 20011                                    |
| 0                              | of H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                 | 20a. Method of Disposition<br>1 Ø Burial 2 ☐ Cremation 3 ☐                         |                                                  | <ul> <li>Place of Dispose</li> <li>cemetery, crem</li> </ul> | sition (Name of<br>natory or other pl | ace)                                           | Date                            | 20c. Location        | · City or To                 | wn, State                                |
| E                              | Peg<br>ment<br>ant: 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                 | 4 ☐ Donetion 5 ☐ Other (Specif                                                     |                                                  | aryland :                                                    | National                              | L Cem 2                                        | -18-08                          | Laurel,              | MD                           |                                          |
| Baltimore, Maryland 21215-0020 | Depenting Import any injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury in |                 | 21. Signature of Funerel Service Licer                                             | isee                                             | 22.<br>M.s                                                   | Name end Addr                         | ess of Facility                                | II.                             | T                    |                              | pir recentiti iller salastitutum — L     |
| ш                              | 20 E 2 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                 | IP Man                                                                             | tha (1)                                          |                                                              |                                       | s Funeral<br>Street, NV                        |                                 |                      | DC :                         | 20011                                    |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 | 23a. Party. Enter the disease, or comshock, or heart feilure. List only            | plicetions that caused the d                     |                                                              |                                       |                                                |                                 |                      |                              | Approximate                              |
| 4                              | Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                 | SHOOK, OF HEART TERRITOR. LIST OTHY                                                | one cease on each line.                          |                                                              |                                       |                                                |                                 |                      | 1                            | Interval Between<br>Onset end Death      |
| Ž.                             | /Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                 | Immediate Ceuse (Final disease or condition                                        | Aspiratio                                        | n Pnaumo                                                     | nia                                   |                                                |                                 |                      | 1                            |                                          |
|                                | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                 | resulting in death)                                                                |                                                  | o (or as a consequ                                           |                                       |                                                |                                 |                      | - 1                          |                                          |
|                                | D =                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ner             |                                                                                    | Dementia                                         | (0, 00 0 00,000)                                             |                                       |                                                |                                 |                      |                              |                                          |
|                                | cuted<br>nd<br>rensi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ani             | Sequentially list conditions                                                       | D                                                | o (or es e consequ                                           | uence of):                            |                                                |                                 |                      |                              |                                          |
| Ō,                             | an e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Ä               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Prostate                                         | Cancer                                                       | •                                     |                                                |                                 |                      | į                            |                                          |
| 376                            | ate br                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | edical Examiner | Ceuse (Disease or injury<br>thet initiated events<br>resulting in death) Last      | C                                                | (or as a consequ                                             | ience of):                            |                                                |                                 |                      |                              |                                          |
| x 68760,                       | eath certificete be executed<br>attending physician end<br>I for use as the burial-trensit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Med             | Todaking in doaliny East                                                           |                                                  |                                                              |                                       |                                                |                                 |                      | -                            |                                          |
|                                | th ce<br>rendii                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 | •                                                                                  | d                                                |                                                              |                                       |                                                |                                 |                      | -                            |                                          |
|                                | 0 0 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Physician       | Part II. Other significant conditions of                                           | ontributing to death but not                     | resulting in the un                                          | derlying cause g                      | iven in Part I.                                | 23b. Did                        | tobacco use co       | ntribute to                  | the cause of death?                      |
| P.<br>O.                       | The law requires that the ste hes been signed by th pege 2 should be detache                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | F)              |                                                                                    |                                                  |                                                              |                                       |                                                | 10                              | Yes 2⊠No             | 3 ☐ Prob                     | sabiy 4 🗆 Unknown                        |
|                                | as the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | b               |                                                                                    |                                                  |                                                              |                                       |                                                |                                 |                      | ,                            |                                          |
| ב                              | v require<br>been si<br>should                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Completed       |                                                                                    |                                                  |                                                              |                                       |                                                |                                 | en eutopsy<br>ormed? |                              | ere eutopsy findings<br>eileble prior to |
| ပ္ထ                            | aw r                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | be              |                                                                                    |                                                  |                                                              |                                       |                                                |                                 |                      | of c                         | npletion of cause<br>deeth?              |
| Ť                              | ate he                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ĕ               |                                                                                    |                                                  |                                                              |                                       |                                                | 10                              | Yes 2 No             | 10                           | Yes 2□ No                                |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Bec             | 25. Was case referred to medical                                                   |                                                  |                                                              |                                       | 26. Place of Death                             | (Check only                     | one)                 |                              |                                          |
| <u> </u>                       | Physician:<br>r this certific<br>ral director,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 2               | exeminer?<br>1 ☐ Yes 2 ☐XNo                                                        | Hospital: 1 ☐ Inpatient 2                        | ☐ ER/Outpetient                                              | 3□ DOA O                              |                                                |                                 | dence 6 Oth          | er (Specify                  | ()                                       |
| Division of                    | <u>-</u> = □                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                 | 27. Manner of Death                                                                | 28a. Date of Injury<br>(Month, Day Year,         | ·                                                            | 28c. Inju                             |                                                |                                 | how injury occur     |                              |                                          |
| <u></u>                        | Attending F<br>or death.<br>actor: After<br>by the funer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | atio            | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation                                   | )                                                | ) Injury                                                     |                                       | Yes 2 No                                       |                                 |                      |                              |                                          |
| <u> </u>                       | i or Attend<br>efter death<br>Diractor: /<br>I in by the f                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5               | 3 ☐ Suicide 6 ☐ Could not be determined                                            | 28e. Place of Injury - A<br>building, etc. (Spe  | t home, farm, stre                                           | et, factory, office                   |                                                | 28f. Location (                 | Street and Numb      | er or Rurel                  | l Route Number,                          |
| 5                              | s effer<br>s effer<br>si Dirac                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Certification:  | 1 13 1 10 11 10 10                                                                 | building, etc. (Spe                              | iuiy)                                                        |                                       |                                                | Ony or 10                       | WIT, Steley          |                              |                                          |
|                                | To the Hospital or Attend<br>within 24 hours efter deati<br>To the Funeral Director:<br>completely filled in by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                 | 29a. Certifier 1 Certifying Ph                                                     | ysicien: To the best of my k                     | nowledge, death                                              | occurred et the t                     | ime, date and place, a                         | and due to the                  | cause(s) and me      | enner as st                  | ated.                                    |
|                                | he H<br>in 24<br>he Fi<br>plete                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | edical          | one)                                                                               | iner: On the basis of exam<br>and manner stated. | inetion and/or inve                                          | estigation, in my                     | opinion, death occurr                          | ed at the time,                 | date and place,      | and due to                   | the ceuse(s)                             |
|                                | To t<br>Com                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Σ               | 29b. Signature and title of certifier                                              | 1 - 10                                           |                                                              | 29c. Licen                            |                                                |                                 | 29d. Date signe      |                              | Day, Year)                               |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 | 1                                                                                  | Mede M                                           | ID ·                                                         | D53                                   | 691                                            |                                 | 02-13-2              | 2008                         |                                          |
| •                              | (3)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                 | 30. Name and address of person who                                                 | completed cause of death (I                      | tem 23a) (Type, P                                            | Print)                                |                                                |                                 |                      |                              |                                          |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 | Ajay Reddy 6320                                                                    | Democracy Bl                                     | vd, Beth                                                     | nesda, M                              | D 20817                                        |                                 |                      |                              |                                          |
|                                | Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                 | 31. Date filed (Month, Day, Year)                                                  | 32. Registrer's Sig                              | nature                                                       |                                       |                                                |                                 |                      |                              |                                          |
|                                | Registra                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ar              | FEB 1 9 2008                                                                       | Bound St.                                        | September 1                                                  |                                       |                                                |                                 |                      |                              |                                          |

Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9 2<u>008</u> **Physician FEBRUARY** 9:55 P GEORGE Ε. CASH SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH RITCHIE HOSPICE BALTIMORE | Hours | Min. | SEPT 26 1937 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** WASHINGTON, DC 579-52-8250 70 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

"In cortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any nitror to other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County MD PRINCE GEORGE'S NEW CARROLLTON 1 XYes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 6411 LAMONT DRIVE 20784 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Yes 2 □ No NAVY If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No BLACK Specify: ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 10th CONSTRUCTION WORKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILBUR CASH RUTH SAUNDERS 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EMILY CASH/WIFE 6411 LAMONT DRIVE NEW CARROLLTON, MARYLAND 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3 ☐ Removal from State 1 Burial 2 ☐ Cremation FT. LINCOLN CEMETERY 2/15/2008 BRENTWOOD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Survice Licens J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician -VN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine sician and burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) O. 9 Unknown <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been si al director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOS PICE 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide or 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

Registrar

DHMH 17 Rev 1/2001

29b. Signatare and title of certifie

31. Date filed (Month, Day, Year) FEB 1 9 2008

29c. License number

D29071

2-10-2008

DIEUTAN ST # 305 BALTIMONE MDZINOI

and manner stated.

32. Registrar's Sign

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

· ANANDA KRIZHNAN, MD 821

|                            | t                                                                                                                                                                                                                                                                                                 | -               | For State of Ma                                                                                                                                    | -                                                   | e <u>p</u> artment of F<br>Certificate of I                     |                                                      |                                     | giene<br>Reg. No.2008               | 06410                                                |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------|-------------------------------------|-------------------------------------|------------------------------------------------------|
| 0                          | Physicia                                                                                                                                                                                                                                                                                          | n               | 1. Decedent's Name (First, Middle, Last)                                                                                                           |                                                     |                                                                 |                                                      | Date of Dea     Month               | Day Yea                             |                                                      |
|                            | /Medic                                                                                                                                                                                                                                                                                            | al              | Gladys Adele Collins                                                                                                                               |                                                     | Ab City Town o                                                  | r Location of Deatl                                  | Februai                             | 4c. County of De                    |                                                      |
|                            | Examin Funeral Director                                                                                                                                                                                                                                                                           | er              | 4a. Facility Name (If not institution, give street and number)  1327 West Old Philadelphia  5. Social Security Number 217-12-0278  6. Sex 1 M 2X F | (In yrs. last birth                                 | North                                                           | East                                                 | 8. Date of Birl                     | Cecil<br>b, Year) 9. B              | irthplace (State or Foreign<br>Country)<br>aryland   |
|                            | pu »                                                                                                                                                                                                                                                                                              |                 | Usual Residence of Decedent  10a. State 10b. County                                                                                                | 10c. City, Town                                     | or Location                                                     |                                                      |                                     |                                     | 10d. Inside City Limits                              |
|                            | Aaryla<br>f shov<br>ed at                                                                                                                                                                                                                                                                         | ō               | Maryland Cecil                                                                                                                                     |                                                     | East                                                            |                                                      |                                     |                                     | 1 □Yes 2X No                                         |
|                            | the N                                                                                                                                                                                                                                                                                             | Director        | 10e. Street and Number                                                                                                                             |                                                     | 10f. Zip Code                                                   |                                                      |                                     | 10g. Citizen of What                | Country?                                             |
|                            | th with                                                                                                                                                                                                                                                                                           | a               | 1327 West Old Philadelphia                                                                                                                         | Road                                                | 21901                                                           | _                                                    |                                     | United                              | States                                               |
| 036                        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral      | 11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  12. Was Decedent Farmed Forces?  1 Yes, Giver Year or Dates:                 | Ever in U.S.                                        | 13. Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No | lispanic Origin? (S<br>an, Mexican, Puer<br>Specify: | pecify Yes or No<br>to Rican, etc.) | Black, W                            | nerican Indian,<br>nite, etc.<br>White               |
| Š<br>Š                     | 72 ho<br>natur<br>lical I                                                                                                                                                                                                                                                                         | eted            | 15. Decedent's Education<br>(Specify only highest grade completed)                                                                                 | 16a. l                                              | Decedent's Usual Occup<br>(Give kind of work done               | during most of wo.                                   | rkina                               | 16b. Kind of Busines                | ss/Industry                                          |
| Maryland 21215-0036        | ed within 'giene. er than " the Mec                                                                                                                                                                                                                                                               | Completed       | Elementary/Secondary (0-12) College (1-4or 5                                                                                                       |                                                     | Sales Clerk                                                     | al)                                                  |                                     | Boat                                |                                                      |
| and                        | be file                                                                                                                                                                                                                                                                                           | Be              | 17. Father's Name (First, Middle, Last)                                                                                                            |                                                     |                                                                 |                                                      |                                     | Maiden Surname)                     |                                                      |
| <u> </u>                   | hould<br>d Mer<br>marke<br>matic                                                                                                                                                                                                                                                                  | 유               | Stanley Smith  19a. Informant's Name/Relationship (Type. Print)                                                                                    | 19h                                                 | Mailing Address (Street                                         | Carrie                                               |                                     | er City or Town State               | Zin Code)                                            |
| <u>B</u>                   | nd 2 saith an 27 is i                                                                                                                                                                                                                                                                             |                 | Juanita Suppa / Daughter                                                                                                                           | CF                                                  | Mailing Address (Street<br>O Long Beac<br>arlestown,            | h Road<br>Maryland                                   | P·219B2                             | x' 3′50                             | , _, _ ,                                             |
| altimore,                  | ages 1 al<br>ant of Hea<br>t: If item<br>y or othe                                                                                                                                                                                                                                                | Ιij             | 20a. Method of Disposition  1 △ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)                                      | 20b. Place of<br>cemeter                            | Disposition (Name of<br>y, crematory or other place             | ce)   Febr                                           | Date<br>cuary                       | 20c. Location - City                | or Town, State                                       |
| Ħ                          | nit. Partme<br>ortan<br>Injur                                                                                                                                                                                                                                                                     |                 | 21. Signature of Foreign Service Licensee                                                                                                          | Kose E                                              | Bank Cemeter 22. Name and Addre                                 |                                                      | 2008                                | Calvert, ineral Home                |                                                      |
| m                          | Der Jung                                                                                                                                                                                                                                                                                          |                 | Miller                                                                                                                                             |                                                     |                                                                 |                                                      |                                     |                                     | Maryland21901                                        |
|                            | Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                 | <u>.</u>        | Due to (or as Sequentially list conditions                                                                                                         |                                                     | Testinal Be                                                     |                                                      | correspiratorya                     | irrest,                             | Approximate Interval Between Onset and Death UMANGON |
| 68760,                     | ficate be executed<br>physician and<br>sthe burial-transit                                                                                                                                                                                                                                        | edical Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events c.                                                                          | a consequence o                                     |                                                                 |                                                      |                                     |                                     |                                                      |
| P.O. Box (                 | The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as                                                                                                                                                                                 | Physician/Me    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                                            | 2 Fetal death                                       | 3 ☐Ectopic pregnanc<br>5 ☐ Other (specify) _                    | у                                                    |                                     | 23d. Date of<br>Month               | delivery<br>Day Year                                 |
|                            | ires that<br>signed b                                                                                                                                                                                                                                                                             | þ               | Part II. Other significant conditions contributing to death b                                                                                      | ut not resulting in                                 | the underlying cause given                                      | ven in Part I.                                       |                                     |                                     | e to the cause of death?  Probably 4 🗹 Únknown       |
| Division or Vital Records, |                                                                                                                                                                                                                                                                                                   | Completed       |                                                                                                                                                    |                                                     |                                                                 |                                                      | 24a. Was<br>auto<br>perfo<br>1  Yes |                                     |                                                      |
| Vit.                       | sician: Th<br>certificate<br>rector, pag                                                                                                                                                                                                                                                          | Be              | 25. Was case referred to medical examiner?  Hospital: Hospital:                                                                                    |                                                     | Ott                                                             | nos:                                                 | ath (Check only                     |                                     |                                                      |
| ō                          | Phys<br>r this<br>ral dii                                                                                                                                                                                                                                                                         | To              | 27. Manner of Death 28a. Date of Inju                                                                                                              | ıry 28b. T                                          | tpatient 3 DOA Office of 28c. Injury Wo                         | 4 Li Nursing                                         | T                                   | idence 6 Other (5                   | Specify)                                             |
| on                         | nding<br>tth.<br>r: Afte<br>e fune                                                                                                                                                                                                                                                                | ation           | 1 ☑Natural 5 ☐ Pending (Month, Da<br>2 ☐ Accident investigation                                                                                    | y Year) Ir                                          |                                                                 | rk?<br>]Yes 2∐No                                     |                                     |                                     |                                                      |
| Divis                      | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, it                                                                                                                              | Certification:  | 3 Suicide 6 Could not be determined 28e. Place of inj                                                                                              | ury - At home, fai<br>tc. <i>(Sp</i> ec <i>ify)</i> | rm, street, factory, office                                     |                                                      |                                     | (Street and Number of<br>wn, State) | Rural Route Number,                                  |
|                            | ne Hospit<br>n 24 hours<br>ne Funers<br>aletely fille                                                                                                                                                                                                                                             | Medical C       | 29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st                             | of examination an                                   |                                                                 |                                                      |                                     |                                     |                                                      |
|                            | To the To the Comp                                                                                                                                                                                                                                                                                | Me              | 29b. Signature and title of certifier                                                                                                              |                                                     | 29c. Licen                                                      |                                                      |                                     | 29d. Date signed (M                 |                                                      |
|                            |                                                                                                                                                                                                                                                                                                   |                 | Vaclider S M)                                                                                                                                      | )                                                   | D00                                                             | 23322                                                |                                     | 2.15.                               | 2008                                                 |
|                            | 8                                                                                                                                                                                                                                                                                                 |                 | 30. Name and address of person who completed cause of o                                                                                            | 118 N                                               | Type, Print)                                                    | Suite 3B                                             | , Elk                               | Ton MD 21                           | 921                                                  |
| V                          | Sta<br>Regist                                                                                                                                                                                                                                                                                     |                 | 31. Date filed (Month, Day, Year) 32. Registr                                                                                                      | rar's Signature                                     | Sparke                                                          |                                                      |                                     |                                     |                                                      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 8:40 A M James Lake Church February 16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** East New Market 5611 Mt. Holly Road Dorchester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

July 12, 1923 North Carolina Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** M 2 □ F Davs Hours Min. Director 216-16-7911 84 Usual Residence of Decedent filed within 72 hours after death with the Marylan 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notifled at 1 ☐ Yes 2 No Directo MD Dorchester East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5611 Mt. Holly Road 21631 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 X No Specify. Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) owner operator tire repair 8 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Franklin Church Martha Caroline Yates 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Louise Church wife 5611 Mt. Holly Rd., East New Market, MD 21631 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) East New Market Cem. 2/19/08 East New Market, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** letustat. years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 been signe should be o 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy page performed 2**)** No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di

Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

altimore,

State

Registrar

Medical

Mary S. DeShields 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a Certifier

M.D.

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

401 Purdy St, Suite 101, Easton, MD 21601

FEB 1 9 2008 ▶



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1- State Amend PI, line b-d, 25,27,28a-f, per Fee 160 Call Color Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MARVIN C. POSS 10:16 PM 01 2008 JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JUHNS HOPICINS BAYVIEW MEDICAL CENTER BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/1/1920 **Funeral №** M 2 F Months Days Hours 87 234-22-3128 Director West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Marylan teath and Mental Hygiene. m 27 is marked other than "natural", or Items 23a or 28a-f show her traumatic event, the Mediral Examiner must be notified at MD Harford Whiteford 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1509 Ridge Road 21160 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 XN0 altimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify 2 Specify White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coal Miner Coal Mining 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William H. Doss Zilphie Parish မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nit. Pages 1 and 2 startment of Health ar sortant: If Item 27 is y Injury or other tre Naomi Anders/Daughter 1511 Ridge Road, Whiteford, Maryland 21160 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Bel Air Mem. Gardens 1/5/2008 Bel Air, Maryland nure of Funeral Service 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 Part / Foter the disease, or con shock, or heart failure. List only complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Immediate Cause (rdisease or condition resulting in death) MAR THUS **Physician** ULSELESS ELECTRICAL /Medical Due to (or as a consequence of) Examiner CARDIAL ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and the detached for use as the burial-transit SEPTIL SHOCK BY MEDICAL Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical Subdural Hematoma IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 PNo cate has been sig , page 2 should b 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 □ Yes 1∐ Yes 2V No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 1 Nnpatient P 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury subject fell getting out of chair Dec. 20, 2007 1 ☐ Yes 2 X No death. 2 X Accident 3 Suicide after death unk. completely filled in by the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1509 Ridge Rd. Whiteford, MD To the Hospital within 24 hours a To the Funeral D 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tirne, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 JANUARY 2008

State Registrar MICHAEL

DHMH 17 Rev 1/2001

4940 EASTERN AVENUE

BALTIMORE

mo

21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S

82. Registrar's Signature

J. DOREI

3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 2:00 P M February 10, 2008 Stanley Dosik /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 1**X** M 2□ F 09/18/1918 89 579**-**38-5292 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No Director Chevy Chase MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 8100 Connecticut Avenue, #414 20815 by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1∑Yes 2 □ No
If Yes, Give
Year or Dates:

1 ☐ Yes 2 No

(Give kind of work done during most of working life. DO NOT use retired)

16a. Decedent's Usual Occupation

Export Manager

20b. Place of Disposition (Name of cemetery, crematory or other place)

WW II

College (1-4or 5+)

Black, White, etc.

Scientific Instruments

Specify: White

16b. Kind of Business/Industry

20c. Location - City or Town, State

18. Mother's Name (First, Middle, Maiden Surname)

Esther Dosik

11221 Korman Drive Potomac, MD 20854

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

Be

၉

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

1 X Burial 2 □ Cremation 3 X Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Natasha Prtina Haag,

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

Harry Dosik

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

Edward Dosik-Son

19a. Informant's Name/Relationship (Type. Print)

**Funeral** 

Director

**Physician** /Medical **Examiner** 

burial-tran

Division or Vital Records, P.O. Box 68760,

|                | 1 X Bunal 2 □ Cremation 3 X F<br>4 □ Donation 5 □ Other (Specify,                                           | Removal from State King                                                                                            | David Mem.                                       | Grdns 02/1                                          | 3/2008 F                                     | alls Chur                                         | ch, VA                                             |  |  |  |
|----------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------|----------------------------------------------|---------------------------------------------------|----------------------------------------------------|--|--|--|
|                | 21. Signature of Funeral Service Licens                                                                     | iee                                                                                                                | 22. Name and Inc. 109                            | Address of Facility Edv<br>1 Rockvill               | ward Sage<br>e Pike Ro                       | l Funeral                                         | Direction, MD 20852                                |  |  |  |
|                | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only o                              | one cause on each line.                                                                                            |                                                  |                                                     | c or respiratory arres                       | st,                                               | Approximate<br>Interval Between<br>Onset and Death |  |  |  |
|                | disease or condition resulting in death)                                                                    | a. Congestive He                                                                                                   |                                                  | re                                                  |                                              |                                                   |                                                    |  |  |  |
|                |                                                                                                             | Due to (or as a consequence                                                                                        | e of):                                           |                                                     |                                              |                                                   |                                                    |  |  |  |
|                | Sequentially list conditions,                                                                               | b. <u>Pneumonia</u> Due to (or as a consequence                                                                    | 04):                                             |                                                     |                                              |                                                   |                                                    |  |  |  |
|                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequence                                                                                        | , oi).                                           |                                                     |                                              |                                                   |                                                    |  |  |  |
| 2              | that initiated events resulting in death) Last                                                              | c<br>Due to (or as a consequence                                                                                   | of):                                             |                                                     |                                              |                                                   |                                                    |  |  |  |
| ì              |                                                                                                             | Due to (or as a consequence                                                                                        | , OI).                                           |                                                     |                                              |                                                   |                                                    |  |  |  |
| 2              |                                                                                                             | d                                                                                                                  |                                                  |                                                     |                                              |                                                   |                                                    |  |  |  |
| y sickall/live | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                     | 23c. If yes, outcome pf pregnancy<br>1 ☐ Live birth 2 ☐ Fetal deat<br>4 ☐ Pregnant at time of death<br>9 ☐ Unknown | th 3 ☐ Ectopic prec<br>5 ☐ Other (spec           |                                                     | 23d. Date of de<br>Month                     | elivery<br>Day Year                               |                                                    |  |  |  |
| n by r         | Part II. Other significant conditions co                                                                    | entributing to death but not resulting                                                                             | in the underlying cau                            | se given in Part I.                                 |                                              |                                                   | to the cause of death?                             |  |  |  |
| complete       | -                                                                                                           |                                                                                                                    |                                                  |                                                     | prior to death?                              | autopsy findings available completion of cause of |                                                    |  |  |  |
| מ              | 25. Was case referred to medical examiner?                                                                  |                                                                                                                    |                                                  |                                                     | ath (Check only one                          |                                                   |                                                    |  |  |  |
| 2              | 1 ☐ Yes 2 X No                                                                                              |                                                                                                                    | outpatient 3 DOA                                 |                                                     | Home 5 ☐ Resider                             | nce 6 □Other (Sp                                  | ecify)                                             |  |  |  |
| atioii.        | 27. Manner of Death 1                                                                                       | (Month, Day Year)                                                                                                  | Time of 286 Injury M                             | c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No             | 28d. Describe how                            | w injury occurred                                 |                                                    |  |  |  |
| 20111112       | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined                                                     | 28e. Place of injury - At home, f building, etc. (Specify)                                                         | farm, street, factory,                           | office                                              | 28f. Location (Str.<br>City or Town,         | eet and Number or F<br>, State)                   | Rural Route Number,                                |  |  |  |
| ancai          | 29a. Certifier (Check only one) 1 X Certifying Phy 2 ☐ Medical Exam                                         | ysician: To the best of my knowledge inner: On the basis of examination a and manner stated.                       | ge, death occurred at<br>and/or investigation, i | the time, date and place<br>n my opinion, death occ | use(s) and manner a<br>ite and place, and di | as stated.<br>ue to the cause(s)                  |                                                    |  |  |  |
| Ä              | 29b. Signature and the certifier                                                                            |                                                                                                                    | 29c.                                             | 29c. License number 29d. Date signed (Mor           |                                              |                                                   |                                                    |  |  |  |
|                |                                                                                                             |                                                                                                                    | 4                                                | February 12, 2008                                   |                                              |                                                   |                                                    |  |  |  |

DHMH 17 Rev 1/2001

State Registrar 00061307-

8600 Old Georgetown Road Bethesda, MD 20814

|           |                                                                                                                                                                                                                                                                                                  |                  | 1 - For amend #5 Per Registrar AMEND #5 per FH2/ 1. Decedent's Name (First, Middle, Last                    | 2 PH G87 7 13<br>2 15/08, BMW, Mo                                    | 3/11/<br>3o  | 0852F                      | rtificate of                                  | ieaith ai<br>Death                | na ivier                       |                              | giene                         | 008                           | 06415                                       |
|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------|----------------------------|-----------------------------------------------|-----------------------------------|--------------------------------|------------------------------|-------------------------------|-------------------------------|---------------------------------------------|
|           | Physicia                                                                                                                                                                                                                                                                                         | an               |                                                                                                             |                                                                      |              |                            |                                               |                                   |                                | Date of Dea<br>Month         | ith<br>Day                    | Year                          | 3. Time of Death                            |
|           | /Medic                                                                                                                                                                                                                                                                                           | al               | 4a. Facility Name (If not institution, give                                                                 | Ebenezer                                                             |              | Dadso                      |                                               | ut continue of l                  |                                | bruary                       | 11                            | 2008                          | 10:11 a <sub>M</sub>                        |
|           | Examin                                                                                                                                                                                                                                                                                           | er               | Bowie Health Car                                                                                            |                                                                      |              |                            | 4b. City, Town, o                             | r Location of i<br>Bow <b>i</b> e | Death                          |                              |                               | nty of Death<br>nce Geor      | ego Le                                      |
|           | Funeral                                                                                                                                                                                                                                                                                          |                  | 599 al Security Number 6. S                                                                                 |                                                                      | (In yrs. la  | st birthday                | If Under 1 Year                               | If Under 24                       | 4 Hrs. 8.                      | Date of Birtl<br>(Month, Day |                               |                               | place (State or Foreign                     |
|           | Director                                                                                                                                                                                                                                                                                         |                  | 571-11-2004 Usual Residence of Decedent                                                                     | M 2□F                                                                | 52           | Yrs.                       | Months Days                                   | Hours                             | Min. Au                        | (Month, Day<br>1gust 2       | 7, Year)<br>7, 1955           | Cour                          | Ghana Ghana                                 |
|           | /land<br>ow                                                                                                                                                                                                                                                                                      |                  | 10a. State 10b. County                                                                                      |                                                                      | 10c. City,   | Town or L                  | ocation                                       |                                   |                                |                              |                               | 1                             | 0d. Inside City Limits                      |
|           | Mary<br>a-f sh                                                                                                                                                                                                                                                                                   | tor              | Maryland Prince Ge                                                                                          | orge's                                                               |              |                            |                                               | Bowie                             |                                |                              |                               |                               | 1 ☐ Yes 2 🖺 No                              |
|           | th the<br>or 284<br>e not                                                                                                                                                                                                                                                                        | )ire             | 10e. Street and Number                                                                                      |                                                                      |              |                            | 10f. Zip Code                                 |                                   |                                |                              | 10g. Citizen o                | of What Cour                  | ntry?                                       |
|           | 23a ust b                                                                                                                                                                                                                                                                                        | Funeral Director | 17127 Russet Driv                                                                                           | е                                                                    |              |                            |                                               | 20716                             |                                |                              |                               | U.S.A                         | ١.                                          |
|           | er de                                                                                                                                                                                                                                                                                            | nue              | 11. Marital Status                                                                                          | 12. Was Decedent E<br>Armed Forces?                                  |              | . 13.                      | Was Decedent of H<br>If Yes, specify Cub      | lispanic Origi<br>an, Mexican,    | in? (Specify<br>Puerto Rica    | Yes or No-<br>an, etc.)      | 14. R                         | lace - Americ<br>lack, White, |                                             |
| 50        | should be filed within 72 hours after death with the Maryland nd Mental Hygjene.<br>marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at                                                                                                | by F             | 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced                                                      | 1 ☐ Yes 2 ☒ N<br>If Yes, Give<br>Year or Dates:                      | 10           |                            | 1 ☐ Yes 2 ☒ No                                | Specify:                          |                                |                              | Spec                          | cify:                         | B1ack                                       |
| 2-0030    | 72 hou                                                                                                                                                                                                                                                                                           |                  | 15. Decedent's Ed                                                                                           | lucation                                                             |              | 16a. Dece                  | edent's Usual Occup<br>e kind of work done    | ation                             | -6                             | I                            | 16b. Kind of                  | Business/In                   |                                             |
| Ž         | ithin 7<br>ne.<br>nan "r                                                                                                                                                                                                                                                                         | Completed        | (Specify only highest gra                                                                                   | College (1-4or 5                                                     | +)           | life.                      | DO NOT use retire                             | during most o                     | or working                     |                              |                               |                               |                                             |
| 7         | led will help with the her the                                                                                                                                                                                                                                                                   |                  | 12                                                                                                          |                                                                      |              |                            | Accounts Ma                                   |                                   | . N                            |                              |                               |                               | Service                                     |
| ylana     | the final Hed of                                                                                                                                                                                                                                                                                 | Be c             | 17. Father's Name (First, Middle, Last) Emmanuel Dadson                                                     |                                                                      |              |                            |                                               |                                   |                                |                              | Maiden Surn                   | ame)                          |                                             |
| Š         | should<br>nd Me<br>mark<br>matic                                                                                                                                                                                                                                                                 | 욘                | 19a. Informant's Name/Relationship (                                                                        | Type, Print)                                                         |              | 19b. Mail                  | ing Address (Street                           |                                   | Beatric<br>ror <i>Bural Bi</i> |                              |                               | vn State Zir                  | Code)                                       |
| Z<br>Z    | Hilda Dadson - Wife 17127 Russet Drive, Bowi                                                                                                                                                                                                                                                     |                  |                                                                                                             |                                                                      |              |                            |                                               |                                   |                                |                              |                               | m, otato, z.p                 | , Gode,                                     |
| ē,        | of Hei                                                                                                                                                                                                                                                                                           |                  | 20a. Method of Disposition                                                                                  |                                                                      | 20b. Pla     | ace of Disp                | osition (Name of<br>ematory or other pla      | i                                 | Date                           |                              | 20c. Locatio                  | n - City or To                | own, State                                  |
| Ĕ         | Page<br>Trent<br>ant: If<br>ury or                                                                                                                                                                                                                                                               |                  | 1 ☑ Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif                                                  |                                                                      |              | •                          | oln Cemeter                                   | i                                 | arch 8,                        | 2008                         | Brentwo                       | ood, Mai                      | ryland                                      |
| parumore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                  | 21. Signature of Euneral Service Licer                                                                      | nsee                                                                 |              | H                          | 22. Name and Addre<br>ines-Rinald             | i Funera                          | al Home                        |                              |                               |                               |                                             |
|           |                                                                                                                                                                                                                                                                                                  |                  | 23a. Part 1 Enter the disease, or com<br>shock, or heart failure. List only                                 | plications that caused                                               | the death.   |                            | 1800 New Ha                                   |                                   |                                |                              |                               | ng, Mary                      | Approximate Interval Between                |
|           | Physician                                                                                                                                                                                                                                                                                        |                  | Immediate Cause (Final                                                                                      |                                                                      |              |                            |                                               |                                   |                                |                              |                               |                               | Onset and Death                             |
|           | /Medical                                                                                                                                                                                                                                                                                         |                  | disease or condition resulting in death)                                                                    | a. Metastat<br>Due to (or as                                         |              |                            | c cancer                                      |                                   |                                |                              |                               |                               | 1 year                                      |
|           | Examiner                                                                                                                                                                                                                                                                                         | _                | Sequentially list conditions.                                                                               | b                                                                    |              |                            |                                               |                                   |                                |                              |                               |                               |                                             |
|           | sit sed                                                                                                                                                                                                                                                                                          | nine             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a                                                      | a conseque   | ence of):                  |                                               |                                   |                                |                              |                               |                               |                                             |
|           | execut<br>and<br>al-trar                                                                                                                                                                                                                                                                         | Examiner         | that initiated events<br>resulting in death) Last                                                           | C Due to (or as a                                                    | a conseque   | ence of):                  |                                               |                                   |                                |                              |                               |                               |                                             |
| 00/00     | rificate be executed og physician and as the burial-transit                                                                                                                                                                                                                                      | ledical          |                                                                                                             | d                                                                    |              |                            |                                               |                                   |                                |                              |                               |                               |                                             |
| Τ.        | ± 0,10                                                                                                                                                                                                                                                                                           |                  | IF FEMALE:                                                                                                  |                                                                      |              |                            |                                               |                                   |                                |                              |                               |                               |                                             |
| מ<br>מ    | death ce<br>e attendir<br>ed for use                                                                                                                                                                                                                                                             | ian/l            | 23b. Was decedent pregnant in the past 12 months?                                                           | 23c. If yes, outcome<br>1 ☐ Live birth                               | 2 ☐ Fetal o  | death 3                    | □Ectopic pregnanc                             | y                                 |                                |                              |                               | Date of delive                | ery<br>Day Year                             |
|           | w requires that the death cer<br>been signed by the attendin<br>should be detached for use                                                                                                                                                                                                       | Physician/N      | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                                                                               | 4□Pregnant at<br>9□Unknown                                           | time of de   | ath 5                      | Other (specify) _                             |                                   |                                | -                            |                               |                               | Day Tour                                    |
| ,<br>T    | The law requires that the site has been signed by the bage 2 should be detache                                                                                                                                                                                                                   | by Pr            | Part II. Other significant conditions                                                                       | contributing to death bu                                             | it not resul | ting in the                | underlying cause giv                          | en in Part I.                     |                                | 23e. Did to                  | obacco use co                 | ontribute to t                | he cause of death?                          |
| coras,    | equire<br>en sig<br>ould b                                                                                                                                                                                                                                                                       |                  |                                                                                                             |                                                                      |              |                            |                                               |                                   | _                              | 1 🗆 \                        | /es 2⊠No                      | 3 ☐ Proi                      | oably 4 □Unknown                            |
| ပ<br>ပ    | law re<br>as be<br>2 sho                                                                                                                                                                                                                                                                         | Completed        |                                                                                                             |                                                                      |              |                            |                                               |                                   | [                              | 24a. Was                     |                               | b. Were auto                  | psy findings available mpletion of cause of |
| <u> </u>  | sician: The law<br>certificate has t<br>irector, page 2 s                                                                                                                                                                                                                                        | Com              |                                                                                                             |                                                                      |              |                            |                                               |                                   |                                | perfo                        | rmed?<br>2⊠No                 | death?<br>1 ☐ Yes             |                                             |
| \ I.G.    | Physician:<br>this certific<br>ral director,                                                                                                                                                                                                                                                     | Be               | 25. Was case referred to medical examiner?                                                                  | Hospital:                                                            |              |                            | l Ou                                          |                                   | of Death (C                    | heck only o                  | ne)                           |                               |                                             |
| 5         | <u>&gt;</u> .≅ ⊅                                                                                                                                                                                                                                                                                 | - To             | 1 ☐ Yes 2 ☒ No  27. Manner of Death                                                                         | 1 ☐ Inpatie                                                          |              | R/Outpatie<br>28b. Time    | SIK SO DOA                                    |                                   |                                |                              | dence 6 🗆 0                   |                               | ly)                                         |
| SION      | th.<br>:: After                                                                                                                                                                                                                                                                                  | Certification:   | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation                                                          | (Month, Day                                                          |              | Injury                     | Wo                                            | rk?<br>Yes 2∐N                    |                                | . Describe i                 | low injury occ                | Julieu                        |                                             |
| <u> </u>  | Atter                                                                                                                                                                                                                                                                                            | ifica            | 3 Suicide 6 Could not be determined                                                                         |                                                                      | ry - At hor  | ne, farm, s                | treet, factory, office                        |                                   | 28f.                           |                              |                               | mber or Run                   | al Route Number,                            |
| 5         | ital or<br>rs afte<br>rai Dir<br>led in                                                                                                                                                                                                                                                          | Cert             |                                                                                                             | ballarig, etc                                                        | (Opecny)     |                            |                                               |                                   |                                | City or Tov                  | vii, State)                   |                               |                                             |
|           | To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral                                                                                                                                                              | Medical          | 29a. Certifier 1  Certifying Pt (Check only one) 1  Medical Example 2                                       | nysiclan: To the best on<br>niner: On the basis of<br>and manner sta | examinati    | /ledge, dea<br>on and/or i | ath occurred at the t<br>investigation, in my | me, date and<br>opinion, death    | d place, and<br>th occurred    | due to the<br>at the time,   | cause(s) and<br>date and plac | manner as s<br>ce, and due t  | stated.<br>o the cause(s)                   |
|           | To th<br>withir<br>To th<br>comp                                                                                                                                                                                                                                                                 | Me               | 29b. Signature and title of certifier                                                                       | 1                                                                    |              |                            | 29c. Licen:                                   | se number                         |                                |                              | 29d. Date sig                 | ned (Month,                   | Day, Year)                                  |
|           | 17/                                                                                                                                                                                                                                                                                              |                  | > Seplen &                                                                                                  | rand, M                                                              | D,           |                            | D334                                          | 82                                |                                |                              | Februa                        | ary 15,                       | 2008                                        |
|           | 10                                                                                                                                                                                                                                                                                               |                  | 30. Name and address of person who                                                                          |                                                                      |              | , , , , ,                  |                                               |                                   |                                |                              |                               |                               |                                             |
|           | Sta                                                                                                                                                                                                                                                                                              | to               | Sajeev Anand, M.D.  31. Date filed (Month, Day, Year)                                                       | , 7343 Hanove                                                        |              | _ ,                        | Suite A, Gre                                  | enbelt,                           | Maryl                          | and 207                      | 770                           |                               |                                             |
| SA        | Registr                                                                                                                                                                                                                                                                                          |                  | FEB 1 5 20                                                                                                  |                                                                      | 1            | A.                         | 342)                                          |                                   |                                |                              |                               |                               |                                             |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:15 A<sup>M</sup> Edward Norman Delaney February 2008 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9405 Tobin Circle Potomac Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months 361-12-1118 1 ☑ M 2 🗆 F 80 Davs Director 09/16/1927 Illinois Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits Director Montgomery Potomac 1 ▼ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9405 Tobin Circle 20854 United States 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Yes 2 f Yes, Give <sup>2□No</sup> 1945-1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 Divorced Year or Dates: 1946 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+<u>Attorney</u> <u>Legal</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred E. Delaney Winifred E. Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole P. Delaney / Wife 9405 Tobin Circle Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/17/2008 | Falls Church, VA National Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 15 Years disease or condition resulting in death) Coronary Artery Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Metastatic Merkel Cell Carcinoma 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐xNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1X Yes 2 No 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Injury investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 1 4

George Bolen MD 10215 Fernwood Rd. Suite 404 Bethesda, MD 20817 32 egistrar's Signature 2008

30. Name and address of person who completed cause of death (fem 23a) (Type, Print)



29c. License number

D34069

29d. Date signed (Month, Day, Year)

02/13/2008

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06417 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Greta H. B. Draper 15, 2008 February 10:30 A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Laurel Health & Rehab. Center Laurel Prince George's If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours 1□ M 25 F 92 056-12-5308 Director 08/05/15 York City, N.Y. New Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits r than "netural", or Itams 23a or 28a-f sho Md. Prince George's 1 Ves 2 □ No Director Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6319 Carrington Court 20743 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, et 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2√2 Married 6 African-Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Library Scientist University Library treumatic event, permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If item 27 is marked othe any linjury or other treumatic event 2008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Percival Balfour Helen Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6319 Carrington Ct., Capitol Heights, Maryland 20743 ce of Disposition (Name of Date 20c. Location - City of Town, State Harry R. Draper/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Nat'l. Mem. Park 02/21/08 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Has address of Facility & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 any nate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pneumonia Examiner Due to (or as a consequence of) Dementia or Attending Physician: The law requires that the death certificate be executed Exami use as the bunel-trensi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, ettending physician Physician/Medical Due to (or as a consequence of) page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hypertension signed δ Completed | 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural within 24 hours efter death.

To the Funerel Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Medicai ( 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

,M.D. 005323

20707

State Registrar

31. Date filed (Month, Day, Year)

FEB 19

2008

13635 Baltimore Ave., Laurel, Maryland Darryl Hill, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

|                                |                                                                                                                                                                                                                                                                                                   |                   | For<br>State<br>Registrar                                                                                                                                     | Otate of Mary                                                                          |                              | ertificate of                                                         |                                             | -                                        | Reg. No. 20                            | 08 06418                                                                            |
|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------|---------------------------------------------|------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------|
| ۳                              | Physici                                                                                                                                                                                                                                                                                           | an                | 1. Decedent's Name (First, Middle, La Claire Suzanne T                                                                                                        | ,                                                                                      |                              |                                                                       |                                             | 2. Date of De<br>Month                   | Day                                    | 3. Time of Death                                                                    |
|                                | /Medic                                                                                                                                                                                                                                                                                            |                   | 4a. Facility Name (If not institution, giv                                                                                                                    |                                                                                        |                              | 4b. City. Town. o                                                     | or Location of Death                        | 02/09/                                   | 4c. County of                          | 5:02A. <sup>M</sup>                                                                 |
|                                | Examili                                                                                                                                                                                                                                                                                           | le i              | Anne Arundel Med                                                                                                                                              |                                                                                        |                              | Annapo                                                                |                                             |                                          |                                        | Arundel                                                                             |
| L                              | Funeral<br>Director                                                                                                                                                                                                                                                                               |                   | 204-34-3770                                                                                                                                                   | 7. Age (I                                                                              | n yrs. last birthda<br>Yrs.  | Months Days                                                           | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birt<br>(Month, Da<br>July 31 | th<br>v. Year)                         | 9. Birthplace (State or Foreign<br>Country)<br>Pennsylvania                         |
|                                | /land<br>ow<br>at                                                                                                                                                                                                                                                                                 |                   | Usual Residence of Decedent  10a. State 10b. County                                                                                                           | 10                                                                                     | Oc. City, Town or            | Location                                                              |                                             |                                          |                                        | 10d. Inside City Limits                                                             |
|                                | e Mar<br>a-f sh<br>tifled                                                                                                                                                                                                                                                                         | ctor              | Maryland Prince (                                                                                                                                             | George's                                                                               | Bowie                        |                                                                       |                                             |                                          |                                        | ¹ ★ es 2 No                                                                         |
|                                | ath with the 23a or 28 ust be no                                                                                                                                                                                                                                                                  | Funeral Director  | 10e. Street and Number<br>2811 Buxmont Lane                                                                                                                   | e                                                                                      |                              | 10f. Zip Code<br>2071                                                 | <b>.</b> 5                                  | 4.600                                    | 10g. Citizen of W                      |                                                                                     |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by                | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Kivorced                                                                                   | 12. Was Decedent Eve<br>Armed Forces?<br>1  Yes 2 No<br>If Yes, Give<br>Year or Dates: |                              | 3. Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes (No            | Specify:                                    | ecify Yes or No<br>Rican, etc.)          | Black<br>Specify:                      |                                                                                     |
| 15-                            | n 72 h<br>''natu<br>edica                                                                                                                                                                                                                                                                         | lete              | 15. Decedent's E<br>(Specify only highest gra                                                                                                                 | ade completed)                                                                         | 16a. Dec                     | cedent's Usual Occup<br>ive kind of work done<br>e. DO NOT use retire | pation<br>during most of work<br>d)         | ing                                      | 16b. Kind of Bus                       | siness/Industry<br>of the State                                                     |
| 212                            | d withi<br>giene.<br>r than<br>the M                                                                                                                                                                                                                                                              | Completed         | Elementary/Secondary (0-12)                                                                                                                                   | College (1-4or 5+)                                                                     |                              | nistrative                                                            |                                             |                                          |                                        | roller                                                                              |
| pu                             | e filectal Hyg                                                                                                                                                                                                                                                                                    | BeC               | 17. Father's Name (First, Middle, Last                                                                                                                        | )                                                                                      |                              |                                                                       | 18. Mother's Name                           |                                          |                                        | e)                                                                                  |
| yla                            | iould by Ment                                                                                                                                                                                                                                                                                     | P_                | Bernard A. Tully                                                                                                                                              |                                                                                        | 1                            |                                                                       | Frances                                     |                                          |                                        |                                                                                     |
| Mai                            | id 2 sh<br>Ith and<br>17 is m<br>traum                                                                                                                                                                                                                                                            |                   | 19a. Informant's Name/Relationship (                                                                                                                          |                                                                                        | į                            | ailing Address (Street                                                |                                             |                                          |                                        | ,                                                                                   |
| ē,                             | f Heal                                                                                                                                                                                                                                                                                            |                   | Francine M. Hoffr<br>20a. Method of Disposition                                                                                                               |                                                                                        | 20b. Place of Dis            | D KIPPIEST<br>sposition (Name of<br>crematory or other pla            | 1                                           | Date                                     |                                        | Land 21045 City or Town, State                                                      |
| <u>m</u>                       | Page<br>nent o<br>ant: If<br>ary or                                                                                                                                                                                                                                                               |                   | 1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special                                                                                                  |                                                                                        | Metropo.<br>Crema            | litan                                                                 | 1                                           | /2008                                    | Alexandr                               | cia, Virginia                                                                       |
| 3alti                          | permit. Departn Imports any Inju                                                                                                                                                                                                                                                                  |                   | 21. Signature of Funeral Service Lice                                                                                                                         | nsee                                                                                   | OI CAME                      | 22. Name and Addre                                                    |                                             |                                          |                                        | Funeral Home                                                                        |
|                                | 0 D = 0                                                                                                                                                                                                                                                                                           |                   | 23a. Part1. Enter the disease, or com                                                                                                                         | inlications that caused the                                                            |                              |                                                                       | -                                           |                                          |                                        | Land 20715 Approximate                                                              |
|                                | Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                 | _                 | shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)                                                   | a. ische  Due to (or as a c                                                            | mic lonsequence of):         | sowel<br>c thro                                                       |                                             | от гозряштот у а                         | TES,                                   | interval Between<br>Onset and Death                                                 |
| 68760,                         | The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-fransit                                                                                                                                | dical Examiner    | Sequentially list conditions, if any, leading to Instructions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c                                                                                      |                              |                                                                       |                                             |                                          |                                        |                                                                                     |
|                                | certifi<br>nding<br>use as                                                                                                                                                                                                                                                                        | /Me               | IF FEMALE:<br>23b. Was decedent pregnant                                                                                                                      | 23c. If yes, outcome pf                                                                |                              |                                                                       |                                             |                                          | 23d. Date                              | e of delivery                                                                       |
| P.O. Box                       | the death cer<br>by the attendin<br>ached for use                                                                                                                                                                                                                                                 | Physician/Medical | in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown                                                                                                             | 1⊡Live birth 2 [<br>4⊡Pregnant at tirr<br>9⊡Unknown                                    |                              | 3 □Ectopic pregnand<br>5 □ Other <i>(specify)</i> _                   | Ży                                          |                                          | Mor                                    | ,                                                                                   |
|                                | w requires that the de<br>been signed by the<br>should be detached                                                                                                                                                                                                                                | by                | Part II. Other significant conditions                                                                                                                         | contributing to death but n                                                            | not resulting in the         | e underlying cause giv                                                | ven in Part I.                              | 23e. Did t                               |                                        | ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown                               |
| Records,                       | The law re                                                                                                                                                                                                                                                                                        | Completed         |                                                                                                                                                               |                                                                                        |                              |                                                                       |                                             | 24a. Was<br>auto<br>perfo<br>1□ Yes      | psy p<br>ormed? d                      | Pere autopsy findings available orior to completion of cause of death?  □ Yes 2□ No |
| Vital                          | Attending Physician: The r death. ector: After this certificate haetor: After this certificate haby the funeral director, page                                                                                                                                                                    | BeC               | 25. Was case referred to medical examiner?                                                                                                                    | Hoonitali                                                                              |                              | 1                                                                     | 26. Place of Deat                           |                                          | -                                      |                                                                                     |
| 0                              | Physic<br>rthis<br>ral dire                                                                                                                                                                                                                                                                       | - To              | 1 Yes 2 No 27. Manner of Death                                                                                                                                | Hospital: 1 Impatient 28a. Date of Injury                                              | 2 ER/Outpat                  | Helit SELDOA                                                          |                                             |                                          | dence 6 Other                          |                                                                                     |
| O                              | nding<br>th.<br>: After<br>e fune                                                                                                                                                                                                                                                                 | tion              | 1 Natural 5 Pending 2 Accident investigation                                                                                                                  | (Month, Day Y                                                                          | ear) Injur                   | y Wo                                                                  | rk?<br>]Yes 2∐No                            | Zou. Describe                            | now injury occurr                      | 5u                                                                                  |
| Division or                    | al or Atter<br>s after dea<br>il Director<br>ed in by the                                                                                                                                                                                                                                         | Certification:    | 3 Suicide 6 Could not b<br>4 Homicide determined                                                                                                              |                                                                                        | - At home, farm,<br>Specify) | street, factory, office                                               |                                             | 28f. Location (<br>City or To            | Street and Numbe<br>wn, State)         | er or Rural Route Number,                                                           |
|                                | To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.                                                                                                                                                 | Medical C         | 29a. Certifier (Check only one)  Certifying Pt 2 Medical Example                                                                                              | nysician: To the best of r<br>miner: On the basis of ex<br>and manner stated           | ramination and/or            | eath occurred at the t<br>r investigation, in my                      | ime, date and place,<br>opinion, death occu | , and due to the<br>rred at the time     | cause(s) and ma<br>, date and place, a | nner as stated.<br>and due to the cause(s)                                          |
| )                              | To t<br>with<br>To t                                                                                                                                                                                                                                                                              | Σ                 | 29b. Signature and title of certifier                                                                                                                         | Dep mo                                                                                 |                              | 29c. Licens                                                           | se number<br>58510                          |                                          | 71.1                                   | 1 (Month, Day, Year)                                                                |
|                                | 100                                                                                                                                                                                                                                                                                               |                   | 30. Name and address o person who                                                                                                                             | comple ed cause of deat                                                                | h (Item 23a) (Typ            | pe, Print)                                                            |                                             |                                          |                                        |                                                                                     |
| W.                             | Sta                                                                                                                                                                                                                                                                                               |                   | 31. Date filed (Month Pay, 1783) 20                                                                                                                           | 08 Registrar's                                                                         | Signature                    | 21                                                                    | 00 Medical                                  | Pkwy Am                                  | apolis M                               | 5                                                                                   |
| i.                             | Registr                                                                                                                                                                                                                                                                                           |                   | LFR T 9 50                                                                                                                                                    | 08 Esser                                                                               | # 1g                         | best                                                                  |                                             |                                          |                                        |                                                                                     |

|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 1 _ For                                                                                                                           | State of Ma                                    |                                  | d / Depa                                 |                     | t of H              | ealth a       |                 | ental Hygi                        | - Z U U          | 8             | 06419                               |
|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------|------------------------------------------|---------------------|---------------------|---------------|-----------------|-----------------------------------|------------------|---------------|-------------------------------------|
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | Ragistrar  1. Decedent's Name (First, Middle, Las                                                                                 | 1)                                             |                                  | 061                                      | illicat             | e oi L              | Jeani         |                 | 2. Date of Deat                   | g. No.           |               | 3. Time of Death                    |
|             | Physicia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | Reginald Ward Du                                                                                                                  |                                                |                                  |                                          |                     |                     |               |                 | Month<br>Februar                  | Day              | Year          | 7:20 A <sup>M</sup>                 |
|             | /Medic<br>Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 4a. Facility Name (If not institution, give                                                                                       |                                                |                                  |                                          | 4b. City,           | Town, or            | Location o    |                 | repruar                           | 4c. County of    |               | 7:20 A                              |
|             | Lxamiii                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | C.               | Chesapeake Wood                                                                                                                   |                                                |                                  |                                          |                     | ambr:               |               |                 |                                   | Doro             |               | er                                  |
|             | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | 5. Social Security Number 6. Se                                                                                                   | x 7. Age                                       | e (In yrs. I                     | ast birthday)                            | If Under            | 1 Year              | If Under 2    | 24 Hrs.<br>Min. | 8. Date of Birth<br>(Month, Day,  |                  |               | place (State or Foreign             |
|             | Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 214-07-7139 <sup>12</sup>                                                                                                         | ZM 2□F                                         | 97                               | Yrs.                                     | Months              | Days                | Hours         |                 | July 14,                          |                  |               | vland                               |
| 7           | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | Usuaf Residence of Decedent  10a. State 10b. County                                                                               |                                                | 100 Cib                          | , Town or Lo                             |                     |                     |               |                 |                                   |                  |               | 10d. Inside City Limits             |
|             | show<br>the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2                | MD Dorche                                                                                                                         | stor                                           | Too. Oily                        | 7, 10 WIT OF LO                          |                     | l                   | : -I          |                 |                                   |                  |               | 1 X Yes 2 No                        |
| 7           | 28a-f                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ect              | 10e. Street and Number                                                                                                            | SCEL                                           |                                  |                                          |                     | ambri               | Lage          |                 | 11                                | Og. Citizen of W | hat Cou       |                                     |
| 7           | a or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Funeral Director | 525 Glenburn Av                                                                                                                   | ·0.211.6                                       |                                  |                                          | 10f. Zip            | Code                | 24.6          | 4.3             | 1                                 | -                |               | iiuy:                               |
| 5           | 70 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | eral             | 11. Marital Status                                                                                                                | 12. Was Decedent I                             | Ever in U.                       | S. 13 V                                  | Was Dece            | dent of Hi          | 216'          |                 | ofy Yes or No-                    |                  | SA<br>- Ameri | can Indian,                         |
| 2           | riten                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Fun              | 1 □ Never Married 2 □ Married                                                                                                     | Armed Forces?                                  |                                  | 1                                        | f Yes, spe          | cify Cubai          | n, Mexican    | , Puerto F      | cify Yes or No-<br>Rican, etc.)   |                  | , White,      | etc.                                |
| 3           | ear, o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ру               | 3 ☐ Widowed 4 ☐ Divorced                                                                                                          | 1 □ Yes 2√ N<br>If Yes, Give<br>Year or Dates: |                                  |                                          | 1 🗆 Yes             | 2 <b>X</b> No       | Specify:      |                 |                                   | Specify:         | W             | hite                                |
|             | natur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Completed        | 15. Decedent's Ed<br>(Specify only highest grad                                                                                   |                                                |                                  | 16a. Deced<br>(Give<br>life.             | dent's Usu          | al Occupa           | ation         | t of workir     | 20                                | 16b. Kind of Bu  | siness/lr     | dustry                              |
| 7           | e .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | nple             | Elementary/Secondary (0-12)                                                                                                       | College (1-4or 5                               | i+)                              |                                          |                     |                     |               | or working      | <i>'</i> 9                        | man 1            | o a t         | <b>-</b>                            |
| V           | ygien<br>ygien<br>t, th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | S                | 8                                                                                                                                 |                                                |                                  |                                          | sales               | age                 |               |                 |                                   | real             |               | ace                                 |
|             | ital H<br>id oth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Be               | 17. Father's Name (First, Middle, Last)                                                                                           | al.                                            |                                  |                                          |                     |                     |               |                 | (First, Middle, M                 |                  | 9)            |                                     |
| 7           | 1 Mer<br>narke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <sup>c</sup>     | William J. Dunno                                                                                                                  |                                                |                                  | T                                        |                     |                     |               |                 | Jane Tr                           |                  |               |                                     |
|             | h and 7 is n                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 19a. Informant's Name/Relationship (7  Jane Hessler                                                                               | ype, Print)<br>nied                            | 20                               | 1                                        | -                   |                     |               |                 | Route Number                      | -                |               |                                     |
| ָּט .       | Healt<br>Healt<br>hm 2<br>ther                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 20a. Method of Disposition                                                                                                        |                                                |                                  |                                          |                     |                     |               |                 | East Ne                           | W Marke          |               |                                     |
| 5           | nt of<br>nt of<br>t: if it                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  | N☐ Burial 2 ☐ Cremation 3 ☐                                                                                                       |                                                |                                  | lace of Dispo<br>emetery, crer<br>irdela |                     |                     |               | 2/21            |                                   | Mardela          |               |                                     |
| aitillio    | permit Fages I and 2 should be little within 72 hours after beath with the maryland<br>Department of Health and Mental Hygiene. Interpretate if them 23a or 28a-f show<br>Important: if them 27 is marked other than "natural", or items 23a or 28a-f show<br>any injury or other traumatic event, the Medical Examinar niust the notified at<br>once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1                | 4 □Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen                                                            |                                                | Ма                               |                                          |                     |                     | s of Facilit  |                 |                                   |                  | _             |                                     |
| 0           | Depart                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | BIL                                                                                                                               | 5                                              |                                  |                                          |                     |                     |               | TIL             | omas Fur<br>bridge,               |                  |               | P.A.                                |
| 16          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only                                                      | olications that caused                         | I the death                      |                                          |                     |                     |               |                 |                                   |                  | 713           | Approximate                         |
| P           | hysician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition                                           | one cause on each lir                          | 10.<br>754e i                    | nyeli                                    | LA                  | y to                | 187-          |                 |                                   |                  |               | Interval Between<br>Onset and Death |
|             | /Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | resulting in death)                                                                                                               | a                                              | a conseq                         | uence of):                               | , (                 | 10.                 |               |                 |                                   |                  |               |                                     |
|             | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | Sequentially list conditions.                                                                                                     | D                                              |                                  |                                          | )ene                | nz                  |               |                 |                                   |                  |               |                                     |
| 7           | si s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as                                  | a consequ                        | uence of):                               |                     |                     |               |                 |                                   |                  |               |                                     |
|             | be executed<br>ician and<br>burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | каш              | that initiated events resulting in death) Last                                                                                    | c<br>Due to (or as                             | 2 000500                         | uance of):                               |                     |                     |               |                 |                                   |                  |               |                                     |
| , o         | ate be executed hysician and he burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | calE             |                                                                                                                                   | Duo 10 (01 23                                  | a consoqi                        | donce ory.                               |                     |                     |               |                 |                                   |                  |               |                                     |
| -           | phys<br>s the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | `                                                                                                                                 | d                                              |                                  |                                          |                     |                     |               |                 |                                   |                  |               |                                     |
| 7           | Prysician: The law requires mat the beam bettimes this certificate has been signed by the attending phraid director, page 2 should be detached for use as the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Physician/Med    | IF FEMALE:<br>23b. Was decedent pregnant                                                                                          | 23c. If yes, outcome                           | of pregna                        | ıncy                                     |                     |                     |               |                 |                                   | 23d. Date        | a of deliv    | 'erv                                |
| ממ          | atter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | clar             | in the past 12 months?                                                                                                            | 1□Live birth<br>4□Pregnant at                  |                                  |                                          | Ectopic p Other (s) |                     |               |                 |                                   | Mor              |               | Day Year                            |
| ,           | by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | hysi             | 9 Unknown                                                                                                                         | 9□ Unknown                                     |                                  |                                          |                     |                     |               |                 |                                   |                  |               |                                     |
|             | ned b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | by P             | Part II. Other significant conditions of                                                                                          | ontributing to death b                         | ut not res                       | ulting in the u                          | nderlying           | cause give          | en in Part I. |                 | 23e. Did tol                      | acco use contr   | ibute to      | the cause of death?                 |
| ž           | an sig                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                   |                                                |                                  |                                          |                     |                     |               |                 | 1 □ Ye                            | s 2 No           | 3 ☐ Pro       | bably 4 Honknown                    |
| ecords,     | aw re<br>Is be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ompleted         |                                                                                                                                   |                                                |                                  |                                          |                     |                     |               |                 | 24a. Was a                        |                  | Vere aut      | opsy findings available             |
|             | ate ha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | E                |                                                                                                                                   |                                                |                                  |                                          |                     |                     |               |                 | perform                           | ned?             | eath?         | 2 A                                 |
| N II G      | artifica<br>ctor.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | BeC              | 25. Was case referred to medical examiner?                                                                                        |                                                |                                  |                                          |                     |                     | 26. Place     | of Death        | (Check only on                    |                  |               |                                     |
| 5 2         | his ce                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2                | 1 ☐ Yes 2 ☐ No                                                                                                                    | Hospitaf: 1 ☐ Inpatie                          | ent 2 🗆                          | ER/Outpatier                             | nt 3 D              | OA Othe             | Pr. 45 MG     | rsing Hor       | ne 5 🗆 Reside                     | ence 6 Othe      | т (Ѕрес       | ify)                                |
| 5 <i>(</i>  | g egg                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 00:              | 27. Manner eath 1 atural 5 ☐ Pending                                                                                              | 28a. Date of Inju<br>(Month, Da                | ry<br>y Year)                    | 28b. Time o<br>Injury                    |                     | 28c. Injury<br>Work | <b>&lt;</b> ? |                 | 28d. Describe ho                  | w injury occurr  | ed            |                                     |
|             | Attending or death.  sctor: After by the fune                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | catl             | 2 Accident investigation 3 Suicide 6 Could not be                                                                                 | . 1                                            |                                  |                                          | М                   |                     | Yes 2□        |                 |                                   |                  |               |                                     |
| <u> </u>    | or Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of Atter of | Certification:   | 4 Homicide determined                                                                                                             | 28e. Place of Inj<br>building, et              | ury - At ho<br>c. <i>(Specif</i> | ome, farm, sti<br>y)                     | reet, factor        | y, office           |               | 1               | 28f. Location (Si<br>City or Town |                  | er or Rui     | ral Route Number.                   |
|             | ours ours erail                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 29a Certifier 1 Certifying Ph                                                                                                     | ysicien: To the best                           | of mill kno                      | wlad a dalli                             | h spenes            | Car the tier        | eo. Yata an   | of observed     | and this to the m                 | tion and and an  | other ne      | etaht                               |
|             | io the hospital of Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | edical           | (Check only 2 Medical Examons)                                                                                                    | niner: On the basis of<br>and manner sta       | f exam≀na                        | tion and/or in                           | vestigation         | n, in my o          | pinion, dea   | ith occurre     | ed at the time, d                 | ate and place, a | ind due       | to the cause(s)                     |
| :           | withir<br>To th<br>comp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Me               | 29b. Signature and title of certifier                                                                                             | UY                                             |                                  | _                                        | 29                  | c. License          |               |                 | 2                                 | 9d. Date signed  | (Month        | , Day, Year)                        |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | ) well                                                                                                                            | 1 40                                           |                                  |                                          |                     | 00                  | 1792          | 4               |                                   | 2-18-            | 08            |                                     |
|             | 0)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 30. Name and address of person who                                                                                                | U.                                             | leath (ften                      | n 23a) (Type,                            | Print)              |                     |               |                 |                                   |                  |               |                                     |
|             | <u> </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | NOM AN THANKY                                                                                                                     |                                                | BYR                              | NCT                                      | CAP                 | 11R                 | 10ak          | 1               | 102                               | 1613             |               | 63307                               |
| 64.5<br>* 0 | Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 31. Date filed (Month, Day, Year) FEB 1 9                                                                                         | 32. Registr                                    | ar's Signa                       | iture                                    | -                   | ine.                |               |                 |                                   |                  |               |                                     |
|             | Registr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ar               | 1 50 7 3                                                                                                                          | COOL STATE                                     | han                              | 15                                       |                     | E . D               |               |                 |                                   |                  |               |                                     |

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Helen U. Dennis 35 FEB. 4a. Facility Name (If not institution, give street and nu 4b. City, Town, or Location of Death 4c. County of Death Nicomico called 10/0del SAUSOUR If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) July 21, 19 Birthplace (State or Foreign Country) Days 1 M 2 VA 70 231-42-8153 1937 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 No Worcester Berlin 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 312 Maple Avenue, Apt. 19 21811 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ██No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bus Contractor Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Upshur, Sr. Bertha Ayres

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 236 W. Champlost Ave., Philadelphia, PA 19120

Date

2/16/2008

20c. Location - City or Town, State

23d. Date of delivery

29d. Date signed (Month, Day, Year)

2-11-08

SAlisbung, Md. 21801

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

Approximate Interval Between Onset and Death

mo

Snow Hill, MD

**Physician** /Medical **Examiner** 

Physician

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show

Director

Funeral

2

Completed

Be

MD

19a. Informant's Name/Relationship (Type. Print)

4 Donation 5 Dother (Specify)

20a. Method of Disposition

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

Danette L. James/daughter

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

or Attending

Hospital

The law requires that the death certificate be executed

burial-transit physician Physician/Medical as the signed t Completed by director. Be Certification: To this funeral After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Medical 5

> State Registrar

DHMH 17 Rev 1/2001

and manner stated.

E. CARROLL

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

FEB 14 2008

Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

|                |                                                                                                                                          |                      |                                                                                                                                                                                                                     | Type or Prin<br>State of Ma                                             |                                  |                            |                                                         |                                                   | _                                    | _                                                | ible.                                                                                    |  |  |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------|----------------------------|---------------------------------------------------------|---------------------------------------------------|--------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------|--|--|
|                |                                                                                                                                          | _                    | For<br>State<br>Registrar                                                                                                                                                                                           |                                                                         |                                  |                            | ificate of                                              |                                                   | •                                    | Reg. No                                          | 08 06421                                                                                 |  |  |
| B              | Physici                                                                                                                                  |                      | Decedent's Name (First, Middle, Las     EMILY JOYCE I                                                                                                                                                               | ,                                                                       |                                  |                            |                                                         |                                                   | 2. Date of De<br>Month<br>FEB        | Day 14 2008                                      | 3. Time of Death  1:20 P M                                                               |  |  |
|                | /Medio<br>Examir                                                                                                                         | 1000                 | 4a. Facility Name (If not institution, give                                                                                                                                                                         | street and number)                                                      |                                  |                            |                                                         | or Location of Deat                               |                                      |                                                  | y of Death                                                                               |  |  |
|                | Funeral                                                                                                                                  |                      | NATIONAL NAVAL ME  5. Social Security Number 6. S                                                                                                                                                                   |                                                                         | CER<br>e (In yrs. last bi        | rthday)                    | BETI<br>If Under 1 Year                                 | IESDA<br>If Under 24 Hrs                          | 8. Date of Bir                       | th                                               | ONTGOMERY  9. Birthplace (State or Foreign                                               |  |  |
|                | Director                                                                                                                                 |                      | 330-74-3943                                                                                                                                                                                                         | □м <b>ЖХ</b> ғ                                                          | 60                               |                            | Months Days                                             | Hours Min.                                        |                                      | 5, 1947                                          | Berlin, Germany                                                                          |  |  |
|                | Maryland<br>a-f show<br>ified at                                                                                                         | ctor                 | Usual Residence of Decedent  10a. State  Virginia  10b. County                                                                                                                                                      |                                                                         | 10c. City, Tow<br>Alexa          |                            |                                                         |                                                   |                                      | 10d. Inside City Limits<br>1 ☐ Yes 2 ☐ No        |                                                                                          |  |  |
|                | death with the Maryland<br>ms 23a or 28a-f show<br>r must be notified at                                                                 | ral Director         | 10e. Street and Number<br>608 North Overloo                                                                                                                                                                         | k Drive                                                                 |                                  |                            | 10f. Zip Code<br>2                                      | 2305                                              |                                      | 10g. Citizen of USA                              | What Country?                                                                            |  |  |
| 21215-0036     | ours after<br>ral", or ite<br>Examine                                                                                                    | by Funeral           | 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced                                                                                                                                             | Armed Forces?                                                           | 1 ☐ Yes 2 2 1 No<br>If Yes, Give |                            |                                                         | Hispanic Origin? (Sean, Mexican, Puer<br>Specify: | Specify Yes or No<br>to Rican, etc.) | Bla                                              | nce - American Indian,<br>ack, White, etc.<br>Yhite                                      |  |  |
| 15-0           | n 72 h<br>''natu<br>edical                                                                                                               | etec                 | 15. Decedent's Ed<br>(Specify only highest gra                                                                                                                                                                      | ucation<br>de completed)                                                | 16a                              | . Decede<br>(Give ki       | nt's Usual Occu<br>ind of work done<br>O NOT use retire | pation<br>during most of wo                       | rking                                | 16b. Kind of E                                   | Business/Industry                                                                        |  |  |
| 212            | be filed within 72 ho<br>tal Hygiene.<br>d other than "natu<br>event, the Medical                                                        | Completed            | Elementary/Secondary (0-12)                                                                                                                                                                                         | College (1-4or 5<br>5+                                                  | +)                               | 1110. DC                   | Teache                                                  | •                                                 |                                      | Schoo1                                           | System                                                                                   |  |  |
| D              | 2 should be filed a nand Mental Hygin is marked other raumatic event, the                                                                | To Be (              | 17. Father's Name (First, Middle, Last)  18. Mother's Name                                                                                                                                                          |                                                                         |                                  |                            |                                                         |                                                   |                                      | lame (First, Middle, Maiden Surname)<br>e Taylor |                                                                                          |  |  |
|                | permit. Pages 1 and 2 should<br>Department of Health and Mer<br>Important: If item 27 is marke<br>any Injury or other traumatic<br>once. |                      | 19a. Informant's Name/Relationship (Type. Print)  Mr. William Erickson - Husband  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip  608 North Overlook Dr. Alexandria, VA 22 |                                                                         |                                  |                            |                                                         |                                                   |                                      |                                                  |                                                                                          |  |  |
| altimore,      |                                                                                                                                          |                      | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify                                                                                                                           | )                                                                       | cemete                           | ery, crema<br>g <b>ton</b> |                                                         | 1 Cem. 0                                          |                                      | 08 Arli                                          | - City or Town, State ington, VA                                                         |  |  |
| Balt           | permit. Departi Import any Inj once.                                                                                                     |                      | 21. Signature of Pur al Service Licer                                                                                                                                                                               |                                                                         | 1453                             |                            |                                                         | ess of Facility E<br>Braddock                     |                                      |                                                  | Funeral Home<br>ia, VA 22302                                                             |  |  |
|                | Physician<br>/Medical                                                                                                                    |                      | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)                                                                | a. CON                                                                  | GESTIVE                          | HEA                        | the mode of dyi                                         |                                                   | c or respiratory a                   | rrest,                                           | Approximate<br>Interval Between<br>Onset and Death                                       |  |  |
|                | Examiner                                                                                                                                 |                      |                                                                                                                                                                                                                     | Due to (or as a                                                         | a consequence                    | of):                       |                                                         |                                                   |                                      |                                                  |                                                                                          |  |  |
|                | xecuted and and II-transit                                                                                                               | xaminer              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                                                                                   | Due to (or as a                                                         | a consequ <b>e</b> nce           | of):                       |                                                         |                                                   |                                      |                                                  |                                                                                          |  |  |
| 68760,         |                                                                                                                                          | Ш                    | resulting in death) Last                                                                                                                                                                                            | Due to (or as a                                                         | a consequence                    | of):                       |                                                         |                                                   |                                      |                                                  |                                                                                          |  |  |
| .O. Box        | the death certificate be e<br>y the attending physician<br>iched for use as the buria                                                    | by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown                                                                                                                             | 23c. If yes, outcome<br>1 □Live birth<br>4 □ Pregnant at<br>9 □ Unknown | 2 Fetal deatl                    |                            | Ectopic pregnanc<br>Other (spec <i>ify)</i> _           | şy                                                |                                      |                                                  | ate of delivery<br>Ionth Day Year                                                        |  |  |
| rds, P         | w requires that the de<br>been signed by the s<br>should be detached to                                                                  | ed by Pr             | Part II. Other significant conditions o                                                                                                                                                                             | ontributing to death bu                                                 | ut not resulting i               | n the und                  | derlying cause gi                                       | ven in Part I.                                    |                                      | obacco use cor<br>Yes 2 □ No                     | ntribute to the cause of death?  3 □ Probably 4 ሺUnknown                                 |  |  |
| Vital Records, | The law<br>ate has b<br>page 2 sh                                                                                                        | Completed            |                                                                                                                                                                                                                     |                                                                         |                                  |                            |                                                         |                                                   | 24a. Was<br>auto<br>perfe<br>1∐ Yes  | an 24b.<br>psy<br>prmed?<br>2 1 No               | . Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No |  |  |
|                | Physician: Th<br>this certificate<br>al director, pag                                                                                    | Be                   | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No                                                                                                                                                           | Hospital:                                                               |                                  |                            | Otto                                                    | har:                                              | ath (Check only                      |                                                  |                                                                                          |  |  |
| 1 O.           |                                                                                                                                          | n: To                | 27. Manner of Death                                                                                                                                                                                                 | 1 Inpatie<br>28a. Date of Injui<br>(Month, Day                          | ry 28b.                          | Time of Injury             | 3□ DOA   Ott                                            | 4 🗆 Nursing i                                     | Home 5 ☐ Resi<br>28d. Describe       | dence 6 □Ot<br>how injury occu                   |                                                                                          |  |  |
| Division or    | I or Attending<br>after death.<br>Director: After<br>in by the funer                                                                     | Certification:       | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined                                                                                                             |                                                                         | -                                |                            | M 1                                                     | Yes 2□No                                          | 28f. Location (<br>City or To        | Street and Num<br>wn. State)                     | nber or Rural Route Number,                                                              |  |  |
| Ω              | points<br>ours<br>ieral                                                                                                                  |                      | (Check only 2 Medical Exam                                                                                                                                                                                          | vsician: To the best of                                                 | of mv knowleda                   | e, death                   | occurred at the t                                       | ime, date and plac                                | e and due to the                     | cause(s) and n                                   | nanner as stated.                                                                        |  |  |
|                | o the Hos<br>vithin 24 ho<br>o the Fun<br>ompletely                                                                                      | Medical              | one)  29b. Signature and title of certifier                                                                                                                                                                         | and manner sta                                                          | ited.                            |                            | 29c, Licen                                              |                                                   |                                      |                                                  | ned (Month, Day, Year)                                                                   |  |  |

State Registrar

JOON S. YUN L 31. Date filed (Month, Day, Year) FEB 1 9 2008 C USN 32. Registrar's Sign LCDR

30. Name at d address of person who completed cause of at ath (Item 23a) (Type, Print)

0101235221 (VA)

02, 15, 2008 NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

08

| 8-01458                                                                                                                                                                                                                                                                                                                                              |                | Please Type or Print in Black Indelible Ink. Ensure All Copi                                                                |                                           | jible.                         |                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------|------------------------------|
| iraaj N. El Amin                                                                                                                                                                                                                                                                                                                                     |                | State of Maryland / Department of Health and Mental F                                                                       | lygiene                                   | 200                            | 8 0642                       |
|                                                                                                                                                                                                                                                                                                                                                      |                | Registrar Certificate of Death                                                                                              |                                           | g. No.                         |                              |
| Physicia<br>Medical Examir                                                                                                                                                                                                                                                                                                                           |                | 1. Decedent's Name (First, Middle,Last)                                                                                     | <ol><li>Date of Death<br/>Month</li></ol> |                                | 3. Time of Death<br>1057 hrs |
| iedicai Examiii                                                                                                                                                                                                                                                                                                                                      | ier            | Siraaj N. E1-Amin  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deat      | Month<br>February 1                       | 9, 2008<br>4c. County of Death |                              |
|                                                                                                                                                                                                                                                                                                                                                      |                | Prince Georges Hospital Center Cheverly                                                                                     | 31                                        | Prince George                  |                              |
| Funeral                                                                                                                                                                                                                                                                                                                                              | -              | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr                               | s 8. Date of Birtl                        | h(MM/DD/YYYY) 9. Bir           |                              |
| Director                                                                                                                                                                                                                                                                                                                                             |                | 231_68_9778                                                                                                                 |                                           | Foreig                         | ın                           |
|                                                                                                                                                                                                                                                                                                                                                      | ŀ              | Usual Residence of Decedent                                                                                                 | July                                      | 10,1940                        | untry) VA.                   |
| any                                                                                                                                                                                                                                                                                                                                                  | ŀ              | 10a. State 10b. County 10c. City, Town or Location                                                                          |                                           |                                | 10d. Inside City Limits      |
|                                                                                                                                                                                                                                                                                                                                                      |                | D.C. Washington                                                                                                             |                                           |                                | 1 X Yes 2 No                 |
| faryland<br>28a-f show                                                                                                                                                                                                                                                                                                                               | 윙              | 10e. Street and Number 10f. Zip Code                                                                                        | 10                                        | g. Citizen of What Cou         | ntry?                        |
| he Milfied                                                                                                                                                                                                                                                                                                                                           | Director       | 3525 Ames St.#204 20019                                                                                                     |                                           | U.S.A.                         |                              |
| S 3 4th 12                                                                                                                                                                                                                                                                                                                                           |                | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( §                                   | Specify Yes or No-                        | 14. Race - Amer                | ican Indian, Black,          |
| leath leath ritem                                                                                                                                                                                                                                                                                                                                    | Funeral        | 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puert                                               | o Rican, etc.)                            | White, etc.                    |                              |
| after al", o                                                                                                                                                                                                                                                                                                                                         | βF             | 3 Wildowed 4 X Divorced If Yes, Give Year or Dates:                                                                         |                                           | Specify: Bla                   | ck                           |
| ours atur                                                                                                                                                                                                                                                                                                                                            |                | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of             |                                           | 16b. Kind of Business/         | Industry                     |
| 6<br>172 h<br>an "r                                                                                                                                                                                                                                                                                                                                  | ğ              | Elementary/Secondary (0-12) College (1-4 or 5+)                                                                             | urca)                                     | United Way                     |                              |
| 003<br>within<br>piene.<br>ner th                                                                                                                                                                                                                                                                                                                    | ompleted       | 11 Eng. Tech.                                                                                                               |                                           | ,                              |                              |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica                                                                                                                                                                                                                                                               | ပ              |                                                                                                                             | ne (First, Middle, M<br>Nickens           | faiden Surname)                |                              |
| 212<br>Ild be<br>Menta<br>narke                                                                                                                                                                                                                                                                                                                      | o Be           | 19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or                               |                                           | her City or Town State         | Zin Code)                    |
| MD 2<br>nd 2 show<br>alth and 1<br>m 27 is a                                                                                                                                                                                                                                                                                                         | -1             | Myra Addison(Sister) 8204 Aspen Glen Ct., A                                                                                 |                                           | •                              | , <u>Lip</u> 0000/           |
| and 3                                                                                                                                                                                                                                                                                                                                                | -              | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,                                                     | Date                                      | 20c. Location - City or        | Town, State                  |
| DOF<br>ages 1<br>at of F                                                                                                                                                                                                                                                                                                                             |                | 1 Burial 2 Cremation 3 Removal from State crematory or other place)                                                         | 0.0                                       | A1 1 1                         | T7 A                         |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Ex miner must be notified at once.                                | -              |                                                                                                                             |                                           | Alexandria                     | ., VA.                       |
| Ba<br>Depri                                                                                                                                                                                                                                                                                                                                          | ļ              |                                                                                                                             |                                           | eral Home                      | ,                            |
| Physician                                                                                                                                                                                                                                                                                                                                            |                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac     | or respiratory arre                       | est, shock, or heart           | Approximate Interval         |
| /Medical                                                                                                                                                                                                                                                                                                                                             |                | failure. List only one cause on each line.  Immediate Cause (Final disease a. Methadone intoxication                        |                                           |                                | Between Onset and<br>Death   |
| xaminer                                                                                                                                                                                                                                                                                                                                              |                | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):                           | 117                                       |                                |                              |
|                                                                                                                                                                                                                                                                                                                                                      |                | Sequentially list conditions, b                                                                                             |                                           |                                |                              |
|                                                                                                                                                                                                                                                                                                                                                      | <u>ē</u>       | if any, leading to immediate Due to (or as a consequence of):                                                               |                                           |                                |                              |
|                                                                                                                                                                                                                                                                                                                                                      | Examiner       | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):                          |                                           |                                | -                            |
| Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit                                                                                                                                                                                                                                            |                | d                                                                                                                           | _                                         |                                | <u> </u>                     |
| e execian grial -                                                                                                                                                                                                                                                                                                                                    | dical          | W UNPENDED  AMENDED  #23a,27,28a-f, perME,g877 3/6/08 TT                                                                    |                                           |                                |                              |
| 760<br>cate the                                                                                                                                                                                                                                                                                                                                      | Physician/Med  | 230. If yes, outcome of pregnancy                                                                                           |                                           | 23d. Date of deliver           | у                            |
| 68<br>certifi<br>nding<br>se as                                                                                                                                                                                                                                                                                                                      | ä              | 23b. Was decedent pregnant in the past 12 months?                                                                           | nancy                                     | Month                          | Day Year                     |
| Sox<br>leath<br>e atte<br>for u                                                                                                                                                                                                                                                                                                                      | ysic           | 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown                                                                                    |                                           |                                |                              |
| that the control of the detached                                                                                                                                                                                                                                                                                                                     |                | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.      | 23e. Did to                               | bacco use contribute to        | the cause of death?          |
| ords, P.O.                                                                                                                                                                                                                                                                                                                                           | d b            |                                                                                                                             | 1 Yes                                     | 2 No 3 Pro                     | bably 4 🗸 Unknown            |
| of Vital Records, in Physician: The law requirements the this certificate has been sineral director, page 2 should be                                                                                                                                                                                                                                | ompleted       |                                                                                                                             | 24a. Was a                                |                                | utopsy findings available    |
| col<br>e law<br>e has                                                                                                                                                                                                                                                                                                                                | 립              |                                                                                                                             | autop<br>perfor                           | med? death?                    | completion of cause of       |
| tal Reco                                                                                                                                                                                                                                                                                                                                             | ပ              | 25. Was case referred to medical 26.Place of Death (Checi                                                                   | _                                         | 2 No 1 Y                       | es 2 No                      |
| Vital Rec                                                                                                                                                                                                                                                                                                                                            | a              | examiner? [Hospital:   Institute of FD(outstant 2 Door 10ther; ] Augustinet                                                 |                                           | Residence 6 Othe               | ar-                          |
| n of V<br>ding Phy<br>After th<br>funeral d                                                                                                                                                                                                                                                                                                          | 의              | 27. Manner of Death  28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Work?                        | ·                                         | now injury occurred            | ···                          |
| on ding                                                                                                                                                                                                                                                                                                                                              | 틾              | Natural 5 Parties                                                                                                           | unk                                       |                                |                              |
| ivision or Attene after death Director:                                                                                                                                                                                                                                                                                                              | <u>[a</u>      | 2 Accident Investigation 11th 2/19/2000 11th 9.50 dill 1                                                                    |                                           | Street and Number or R         | ural Route Number, City      |
| Division pital or Attent ours after death teral Director:                                                                                                                                                                                                                                                                                            | Certification: | Suicide  4 Homicide  4 Could not be determined (Specify) found at home                                                      | or Town, S<br>3525 Ames                   | tate) Washingt<br>St. Apt 204  | on DC                        |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn |                | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an          |                                           |                                | ted.                         |
| To the Howithin 24 h To the Fun                                                                                                                                                                                                                                                                                                                      | Medical        | one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. |                                           |                                |                              |
| F 8 F 8                                                                                                                                                                                                                                                                                                                                              | ₽              | 29b. Signature and title of certifier 29c. License number                                                                   |                                           | 29d. Date signed (Mo           | onth, Day, Year)             |
|                                                                                                                                                                                                                                                                                                                                                      |                | Doma Minenti, n.D. O.C.M.E.                                                                                                 |                                           | February 20, 20                | 08                           |
|                                                                                                                                                                                                                                                                                                                                                      | ŀ              | 30. Name and address of person who completed cause of death (Item 23a)                                                      |                                           |                                |                              |
| SP                                                                                                                                                                                                                                                                                                                                                   |                | Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, N                                              | MD 21201                                  |                                |                              |
| Sta                                                                                                                                                                                                                                                                                                                                                  | _              | 31. Date file (hohs), Gay Read UU 0 32. Registrar's Signature                                                               |                                           |                                |                              |
| Registi                                                                                                                                                                                                                                                                                                                                              | rar            | St. Bale line ( Moley, Cary) early ( )                                                                                      |                                           |                                |                              |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Druley Physician Fe 12:50 PM Rosine Evans 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham P. G. 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 X F 213-54-8226 **Director** May 16, 1936 England Usual Residence of Decedent 10c. City. Town or Location 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Prince George's Director Maryland Bowie 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12314 Rambling Lane 20715 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the M College (1-4or 5+) 12 Office Manager SSAI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Mabe 1 Ba 11 ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas L. Evans/ Husband 12314 Rambling Lane, Bowie, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 2/12/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** ASYSTOLE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner TICEMI Sequentially list conditions, if any, leading to immediate cause. Line, Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed EBRILE ng physician and as the burial-trans NEUTROPENIA Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending for use as esn If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 pronths? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performe certificate or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2008 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who cor 31. Date filed (Month, Day, Year) FEB 1 3 2008 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

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| Marie   Antisionette   Ford   February   8,2008   6:19   7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | E          | Physici                                    | an    | 1. Decedent's Name (First, Middle            | ,                          |                            |                |                         |                         |                            |                         | 2. Date of Dea                   | ath                | Year          | 3. Time of                        | Death                |
| Figure   Prince   Regional Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |            | /Media                                     | al    |                                              |                            |                            |                | 4h Ciby                 | Tours                   | . I acation .              |                         |                                  | ry 8,2             | 800           |                                   | P M                  |
| Social Social Content   The Part   The Par   |            | Examin                                     | er    |                                              |                            | 1)                         |                | _                       |                         | Location                   | or Death                |                                  |                    | ,             |                                   |                      |
| December   Color   C   |            | Funeral                                    |       | 5. Social Security Number                    | 6. Sex 7. A                |                            | ast birthday)  | If Under                | 1 Year                  |                            |                         | 8. Date of Birt                  | h                  | 9. Birth      | place (State o                    | r Foreign            |
| 10.0 State   10.0 County   10.0 Colly   10   | Ľ          | Director                                   |       |                                              | 1 □ M 2 <del>Q</del> F     | 60                         | Yrs.           | WOITE                   | Days                    | Hours                      | IVIII I.                | April 0                          | 6,1947             |               |                                   | , DC                 |
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| Physician Physician (Mociola)  Framework Cause Final Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest the final cause of final trimedate Cause Final Enter the disease, or complications and cause of final trimedate Cause Final Enter the disease, or complications and cause of final trimedate Cause Final Enter the disease, or complications are sufficient to proceed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest the death of Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christ and Enter the Mocion Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian Christian | Ba         | Depart Impo                                |       |                                              |                            |                            | 3              | 831 G                   | eore                    | ria Ax                     | " Lat                   | ney's ]<br>W. Wash               | Tunera             | 1 Home        | 20011                             |                      |
| Physician Medical Examiner    Physician Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Ę          | ***                                        |       | 23a. Part1. Enter the disease, or            | complications that caus    | ed the death               |                |                         |                         |                            |                         |                                  |                    | 11, 10        |                                   | 6                    |
| Doe to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            | Physician                                  |       | Immediate Cause (Final                       |                            |                            | ral H          | emorr                   | hace                    |                            |                         |                                  |                    | 1             | Onset and I                       | Death                |
| Sequentially list conditions and light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of the light part of t |            |                                            |       | resulting in death)                          | Due to (or a               | as a consequ               | ence of):      |                         |                         |                            |                         |                                  |                    |               |                                   | -                    |
| State   Lineage of Plant   Linea |            |                                            | -e    | Sequentially list conditions,                |                            |                            |                |                         |                         |                            |                         |                                  |                    |               |                                   |                      |
| Spood   Part   Common   Part    |            | cuted<br>d<br>ansit                        | min   | Gause (Disease or injury                     | Diabe                      | tes Me                     | llitu          | s                       |                         |                            |                         |                                  |                    | 1             |                                   |                      |
| FFEMALE:   23d. Date of delivery   23d. Date of deli   | oʻ         | e exec<br>ian an<br>ırial-tr               |       | resulting in death) Last                     | Due to (or a               | as a consequ               | ence of):      |                         |                         |                            |                         |                                  |                    |               |                                   |                      |
| FFEMALE:   23d. Date of delivery   23d. Date of deli   | 876        | cate b                                     | dica  |                                              | d                          |                            |                |                         |                         |                            |                         |                                  |                    |               |                                   |                      |
| 24a. Was an autopsy performed? 1   Yes 2   No   25. Was case referred to medical examiner? 1   Yes 2   No   26. Place of Death   Check online one    9 X        | certifii<br>nding p                        | /Me   |                                              | 23c. If yes, outcom        | ne pf pregnai              | ncy            |                         |                         |                            |                         |                                  | 224                | Data of dali  | ivon.                             |                      |
| 24a. Was an autopsy performed? 1   Yes 2   No   25. Was case referred to medical examiner? 1   Yes 2   No   26. Place of Death   Check online one               | death<br>e atter<br>d for u                | iciar | in the past 12 months?                       | 1□Live birth<br>4□Pregnant | 2 ☐ Fetal<br>at time of de | death 3        |                         |                         | ′                          |                         |                                  | 250.               |               | -                                 | Year                 |
| 24a. Was an autopsy performed? 1   Yes 2   No    25. Was case referred to medical examiner? 1   Yes 2   No    25. Was case referred to medical examiner? 1   Yes 2   No    26. Place of Death   Check onli one    27. Manner of Death   Check onli one    28. Date of Injury   Sec. Injury at   North    0.         | at the<br>by th                            | hys   | 9 ☐ Unknown                                  |                            |                            |                |                         |                         |                            |                         |                                  |                    |               |                                   |                      |
| 24a. Was an autopsy performed? 1   Yes 2   No    25. Was case referred to medical examiner? 1   Yes 2   No    25. Was case referred to medical examiner? 1   Yes 2   No    26. Place of Death   Check onli one    27. Manner of Death   Check onli one    28. Date of Injury   Sec. Injury at   North               | res th<br>signed<br>be de                  | by    | Part II. Other significant conditio          | ns contributing to death   | but not resu               | Iting in the u | nderlying c             | ause give               | en in Part I               | l.                      |                                  |                    |               |                                   |                      |
| The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | Sorc       | requi                                      | eted  |                                              |                            |                            |                |                         |                         |                            |                         |                                  |                    |               |                                   |                      |
| State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat   | Rec        | 2 g a                                      | ldm   |                                              |                            |                            |                |                         |                         |                            |                         | autor                            | osy                | prior to c    | topsy findings<br>completion of c | available<br>ause of |
| State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat   | ita        |                                            |       |                                              | 1                          |                            |                |                         |                         | 26 Place                   | e of Deat               |                                  |                    | 1 ☐ Yes       | 2□ No                             |                      |
| State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat   | <u> </u>   | nysici<br>nis cer<br>direct                |       |                                              | Hospital: 1 🔣 Inpa         | itient 2 🗆 E               | ER/Outpatier   | nt 3 DC                 | Oth                     | or.                        |                         |                                  | 10.00              | Other (Spec   | cify)                             |                      |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Syed Sadiq, MD 14333 Laurel Bowie Rd., #208, Laurel, MD 20708                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | n o        | ing Pt<br>Viter th<br>uneral               |       | _                                            | /Adamsh C                  |                            |                | f 2                     | 28c. Injur<br>Worl      | y at<br>k?                 |                         | 28d. Describe                    | now injury o       | curred        |                                   |                      |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Syed Sadiq, MD 14333 Laurel Bowie Rd., #208, Laurel, MD 20708                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | isio       | ttend<br>death.<br>stor: /                 | icati | 3 Suicide 6 Could n                          | ot be 290 Place of it      | inium - At hor             | mo farm of     |                         |                         | Yes 2□                     |                         | 006                              | 24                 |               | (D) A AI                          |                      |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Syed Sadiq, MD 14333 Laurel Bowie Rd., #208, Laurel, MD 20708                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Di<        | after I Direct                             | ertif | 4 ☐ Homicide determi                         | building,                  | etc. (Specify              | r)             | eet, lactory            | , once                  |                            |                         |                                  |                    | umber or Hu   | irai noute ivun                   | nber,                |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Syed Sadiq, MD 14333 Laurel Bowie Rd., #208, Laurel, MD 20708  State 31. Date filed (Month, Day, Year) 32 Registrar's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |            | ospita<br>hours<br>unera<br>ly fille       |       | 29a. Certifier 1 Certifyin                   | g Physician: To the bes    | st of my know              | wledge, deat   | h occurred              | at the tir              | ne, date ar                | nd place,               | and due to the                   | cause(s) an        | d manner as   | stated.                           |                      |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Syed Sadiq, MD 14333 Laurel Bowie Rd., #208, Laurel, MD 20708  State 31. Date filed (Month, Day, Year) 32 Registrar's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |            | the H<br>hin 24<br>the Fi<br>nplete        | ledic | one)                                         | and manner                 | stated.                    | ion and/or in  |                         |                         |                            | atn occur               |                                  |                    |               |                                   | S)                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Syed Sadiq, MD 14333 Laurel Bowie Rd., #208, Laurel, MD 20708  31. Date filed (Month, Day, Year)  32. Registrar's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |            |                                            | -     | 29b. Signature and title of certifier        | - Allora                   | ٠.                         | M              | 1                       |                         |                            |                         |                                  |                    |               |                                   |                      |
| Syed Sadiq, MD 14333 Laurel Bowie Rd., #208, Laurel, MD 20708                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>y</b> \ | 10                                         |       | 30. Name and address of person s             | who completed cause of     | f death (Item              | 23a) (Tyne     |                         | υ <b>∠</b> 4/.          | <u> </u>                   |                         |                                  | Febr               | uary 9        | ,2008                             |                      |
| State 31. Date filed (Month, Day, Year) 32 egistrar's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                            |       | Syed Sadiq, MD                               | 14333 Lau                  |                            |                |                         | 208,                    | Laur                       | e1,                     | MD 2070                          | 8                  |               |                                   |                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Tree       |                                            |       | 31. Date filed (Month, Day, Year)<br>FEB 1 5 | 32 Regis                   | strar's Signat             | ture           |                         |                         |                            |                         |                                  |                    |               |                                   |                      |

DHMH 17 Rev 1/2001

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|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------|-----------------------------------|-----------------------|-------------------------------------------|------------------|----------------------------------------------------------------|----------------------------------|-------------------------|
|                                | Physici                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                   | 1. Decedent's Name (First, Middle, La<br>Richard                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <i>'</i>                            | ller                              |                                                                                                      |                                                             |                               |                                   |                       | 2. Date of Dea<br>Month<br>Feb. 12        | ath<br>Da        |                                                                | 3. Time 6                        |                         |
|                                | /Medic<br>Examir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                   | 4a. Facility Name (If not institution, given Springhouse at Weetler)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                     | nber)                             |                                                                                                      | 4b. City, Tow                                               | n, or Lo                      |                                   |                       | 100. 12                                   | 4c.              | County of Deat                                                 | h                                |                         |
|                                | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   | 5. Social Security Number 6. 9<br>577-62-2791                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                     | 7. Age ( <i>In yr</i> s.          | last birthday)<br>Yrs.                                                                               | If Under 1 You<br>Months Da                                 |                               | f Under 2<br>Hours                | 24 Hrs.<br>Min.       | 8. Date of Birt<br>(Month, Da<br>Dec . 15 | - In             | 0.014                                                          | hplace (State<br>untry)<br>orida | or Foreign              |
|                                | Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | tor               | Usual Residence of Decedent  10a. State 10b. County  DC Nor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ie                                  | 10c. Cit                          | ty, Town or Lo<br>Washi                                                                              | ngton,                                                      | DC                            |                                   |                       |                                           |                  |                                                                | 10d. Inside (                    | City Limits             |
|                                | th with the<br>23a or 28a<br>ust be noti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Funeral Director  | 10e. Street and Number 5041 Dana Place,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | NW                                  | I                                 |                                                                                                      | 10f. Zip Coo                                                | de                            | 016                               |                       |                                           | 10g. Cit         | izen of What Co<br>USA                                         | untry?                           |                         |
| 980                            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                   | 11. Marital Status  1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Armed For                           | <sup>2□ No</sup> 196              | 8-                                                                                                   | Was Decedent<br>If Yes, specify (                           |                               | anic Orig<br>Mexican,<br>Specify: | jin? (Sp∈<br>, Puerto | ecify Yes or No<br>Rican, etc.)           | •                | 14. Race - American Indian, Black, White, etc.  Specify: White |                                  |                         |
| Baltimore, Maryland 21215-0036 | within 72 ho<br>iene.<br>• than "natui<br>the Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Completed by      | 15. Decedent's E<br>(Specify only highest gr<br>Elementary/Secondary (0-12)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                     | -4or 5+)                          | i (Give                                                                                              | dent's Usual Oo<br>kind of work do<br>DO NOT use re<br>yist | one duri                      | on<br>ing most                    | of worki              | ng                                        | Pa               | ralysed<br>Americ                                              | Veter                            | ans                     |
| yland 2                        | ould be filed<br>Mental Hygi<br>arked other<br>atic event, t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | To Be Co          | 17. Father's Name (First, Middle, Las  Cary Fuller                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                     |                                   |                                                                                                      |                                                             |                               | Ва                                | rbar                  | (First, Middle,                           | ing              |                                                                |                                  |                         |
| e, Mar                         | 1 and 2 sho<br>Health and<br>em 27 Is m<br>ther traum                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                   | 19a. Informant's Name/Relationship  Cary Fuller/Brot  20a. Method of Disposition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | , ,                                 | 20b. F                            | ng Address (Street and Number or Rural Route Number and Mark Sq. #402, Port Che sition (Name of Date |                                                             |                               |                                   |                       | , , , , , , , , , , , , , , , , , , , ,   |                  |                                                                |                                  |                         |
| altimor                        | nit. Pages<br>vartment of<br>ortant: If It<br>ortant or o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                   | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Cont | fy)                                 | State Me                          | cemetery, cret<br>tropoli<br>ematory                                                                 | natory or other<br>L <b>tan</b><br>T                        | place)                        | _ i •                             | 2-13<br>/ De          | -08  <br>Vol Fun                          | Alex             | kandria,                                                       |                                  | nia                     |
| m<br>T                         | Deprimental period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the peri |                   | 23a. Part1. Enter the disease, or con shock, or heart failure. List only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | nplications that can be cause on ea | aused the deat                    | 2.2                                                                                                  | 222 Wise                                                    | cons                          | sin A                             | Ave.                  | , N.W.                                    | Wasł             | nington,                                                       | Approxima                        | ate<br>etween           |
|                                | Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                   | Immediate Cause (Final disease or condition resulting in death)  Metastatic Lung Cancer  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                     |                                   |                                                                                                      |                                                             |                               |                                   |                       |                                           |                  |                                                                | Onset and<br>years               |                         |
| 8760,                          | icate be executed<br>physician and<br>s the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | dical Examiner    | Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                     |                                   |                                                                                                      |                                                             |                               |                                   |                       |                                           |                  |                                                                |                                  |                         |
| .O. Box 6                      | eath certif<br>attending<br>for use as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Physician/Medi    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                     | irth 2 ☐ Feta<br>ant at time of c | al death 3                                                                                           | ]Ectopic pregn<br>] Other (specif                           |                               |                                   |                       |                                           |                  | 23d. Date of del<br>Month                                      | ivery<br>Day                     | Year                    |
| <u>α</u>                       | w requires that the d<br>been signed by the<br>should be detached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | by                | Part II. Other significant conditions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | contributing to de                  | eath but not res                  | ulting in the u                                                                                      | nderlying cause                                             | e given i                     | in Part I.                        |                       | 23e. Did to                               |                  | use contribute to<br>☐ No 3 🛣 Pr                               |                                  |                         |
| al Reco                        | The<br>ate h<br>page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Completed         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                     |                                   |                                                                                                      |                                                             |                               |                                   |                       |                                           |                  | death?                                                         | completion of                    | s available<br>cause of |
| Vit                            | Physician: Th<br>r this certificate<br>ral director, pag                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | o Be              | 25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Hospital:                           | npatient 2                        | ER/Outpatier                                                                                         | nt 3 DOA                                                    | Othor:                        |                                   |                       | (Check only o                             |                  | 6 <b>X</b>  Other (Spe                                         | - Нова                           |                         |
| Division or Vital Records,     | Attending r death. ector: After by the fune                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Certification: To | 27. Manner of Death  1 X Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 28a. Date of (Mont)                 | of Injury<br>h, Day Year)         | 28b. Time o<br>Injury                                                                                | f 28c.                                                      | Injury at<br>Work?<br>1 □ Yes |                                   | 10                    | 28d. Describe I                           | how inju         | ry occurred                                                    |                                  |                         |
| ۵                              | Hospital or<br>24 hours afte<br>Funeral DIr<br>tely filled in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                   | 29a. Certifier 1X Certifying P (Check only 2   Medical Exa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | hysician: To the                    | best of my kno                    | owledge, deat                                                                                        | h occurred at the                                           | ne time,<br>my opin           | , date and                        | d place,              | City or Tov                               | cause(s          | and manner as                                                  | stated.                          | (s)                     |
|                                | To the I within 24 To the I complete                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Medical           | one)  29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | and mann                            | per/stated.                       |                                                                                                      |                                                             | cense nu                      |                                   |                       |                                           |                  | ite signed (Mont                                               |                                  |                         |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   | Cum                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | "fork                               | Lun                               | 10                                                                                                   | 1                                                           | MD32                          | 2864                              |                       |                                           |                  | . 13, 20                                                       |                                  |                         |
| -                              | 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                   | 30. Name and address of person who Ari D. Fishman,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | M.D. 2                              | 141 K S                           | St., N.                                                                                              | Print) W. #707                                              |                               |                                   | , D                   | .C. 200                                   |                  | . 13, 20                                                       | -00                              |                         |
|                                | Sta<br>Registi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                   | 31. Date filed (Month, Day, Year)<br>FEB 1.5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2008 32.                            | gistrar's Signa                   | ature A                                                                                              | out                                                         |                               |                                   |                       |                                           |                  |                                                                |                                  |                         |

|            |                                                                                                                                                                           |                | 1 - For<br>State<br>Registrar                                                                                                                                                                                                                                                                            | State of                         | Maryland                         |               | artment of H                                                    |                            | and Men        |                    | - 71111                    | 8                     | 06426                 | ) |
|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------|---------------|-----------------------------------------------------------------|----------------------------|----------------|--------------------|----------------------------|-----------------------|-----------------------|---|
| 4          |                                                                                                                                                                           |                | Decedent's Name (First, Middle, I                                                                                                                                                                                                                                                                        | Last)                            |                                  |               |                                                                 |                            | 2.1            | Date of Deatl      | neg. No.                   |                       |                       | _ |
|            | Physici                                                                                                                                                                   |                | Lasalle Vandyke                                                                                                                                                                                                                                                                                          | Frederick                        |                                  |               |                                                                 |                            |                | Month<br>oruary    |                            | ear                   | 3:04pm <sup>M</sup>   |   |
|            | /Medio                                                                                                                                                                    |                | 4a. Facility Name (If not institution, g                                                                                                                                                                                                                                                                 |                                  |                                  |               | 4b. City, Town, or                                              | Location of                |                | ordary             | 4c. County of              |                       | J.04pm                | _ |
|            | LAAIIII                                                                                                                                                                   | ICI            | St. Thomas Moore                                                                                                                                                                                                                                                                                         |                                  | ,                                |               | Hyattsvi                                                        |                            |                |                    | Prince                     |                       | oe's                  |   |
|            | Funeral                                                                                                                                                                   |                |                                                                                                                                                                                                                                                                                                          |                                  | Age (In yrs. las                 | st birthday)  | If Under 1 Year                                                 | If Under                   | 24 Hrs. 8. [   | Date of Birth      | 9                          | . Birthpla            | ce (State or Foreign  | _ |
| lο         | Director                                                                                                                                                                  |                | 577-50-5841                                                                                                                                                                                                                                                                                              | 1 <b>½</b> M 2□ F                | 70                               | Yrs.          | Months Days                                                     | Hours                      |                | Month, Day, y 2, 1 |                            | Countr                | 11, S.C.              |   |
|            | פ                                                                                                                                                                         |                | Usual Residence of Decedent                                                                                                                                                                                                                                                                              |                                  |                                  |               |                                                                 |                            | 415            | , _, -             | , , , , ,                  |                       |                       |   |
|            | rylan<br>how                                                                                                                                                              |                | 10a. State 10b. County                                                                                                                                                                                                                                                                                   |                                  | 10c. City,                       | Town or Lo    | cation                                                          |                            |                |                    |                            | 10                    | d. Inside City Limits |   |
|            | a-f s                                                                                                                                                                     | S S            | Maryland Prince                                                                                                                                                                                                                                                                                          | George's                         | Hyat                             | tsvil         | le                                                              |                            |                |                    |                            |                       | tX⊡Yes 2 □ No         |   |
|            | or 28                                                                                                                                                                     | Director       | 10e. Street and Number                                                                                                                                                                                                                                                                                   |                                  | •                                |               | 10f. Zip Code                                                   |                            | ·              | 10                 | g. Citizen of Wha          | at Countr             | y?                    |   |
|            | 23a<br>ust b                                                                                                                                                              |                | 4922 Lasalle Road                                                                                                                                                                                                                                                                                        |                                  |                                  |               | 20782                                                           |                            |                | U                  | nited St                   | ates                  | 5                     |   |
|            | ems                                                                                                                                                                       | Funeral        | 11. Marital Status                                                                                                                                                                                                                                                                                       | 12. Was Decede<br>Armed Force    | ent Ever in U.S.<br>es?          | 13.           | Was Decedent of H<br>If Yes, specify Cuba                       | ispanic Ori                | igin? (Specify | Yes or No-         | 14. Race -                 | America<br>White, e   |                       |   |
| 9          | be filed within 72 hours after death with the Maryland that Hyglene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Y.F.           | 1 ☑ Never Married 2 ☐ Married                                                                                                                                                                                                                                                                            | If Yes, Give                     | ☐ No                             |               | 1 □ Yes 2√⊋ No                                                  | Specify:                   |                | , ,                | Specify:                   |                       |                       |   |
| 21215-0036 | ural"                                                                                                                                                                     | d by           | 3 Widowed 4 Divorced                                                                                                                                                                                                                                                                                     | Year or Date                     |                                  |               |                                                                 |                            |                |                    |                            |                       |                       |   |
| 5          | "nat                                                                                                                                                                      | Completed      | 15. Decedent's (Specify only highest                                                                                                                                                                                                                                                                     |                                  |                                  | (Give         | dent's Usual Occup<br>kind of work done o<br>DO NOT use retired | ation<br><i>during mos</i> | at of working  |                    | 16b. Kind of Busin         | ness/Indu             | istry                 |   |
| 12         | within                                                                                                                                                                    | 盲              | Elementary/Secondary (0-12)                                                                                                                                                                                                                                                                              | College (1-4                     | · .                              |               |                                                                 | ,                          |                |                    | Dudasata                   |                       |                       |   |
|            | filed<br>Hygid<br>ther                                                                                                                                                    |                | 17. Father's Name (First, Middle, La                                                                                                                                                                                                                                                                     | est)                             |                                  | DISNW         | asher                                                           | 18 Mothe                   | er's Name /Fir |                    | Private<br>Maiden Surname) |                       |                       | _ |
| Maryland   | be do eve                                                                                                                                                                 | Be             | Major Frederick                                                                                                                                                                                                                                                                                          | ,                                |                                  |               |                                                                 |                            | Murra          |                    | laideir Gurnaine)          |                       |                       |   |
| 2          | d Me<br>mark<br>matic                                                                                                                                                     | P              | 19a. Informant's Name/Relationship                                                                                                                                                                                                                                                                       | (Type Print)                     |                                  | 10h Mailir    | ng Address (Street                                              |                            | ·              |                    | City or Town Ct            | nto Zio /             | 2ada)                 | _ |
| Ma         | d2s<br>than<br>7 Is<br>trau                                                                                                                                               |                | Joyce Frederick                                                                                                                                                                                                                                                                                          |                                  | in Law                           |               |                                                                 |                            |                |                    |                            |                       | Jode)                 |   |
|            | ges 1 and 2 should<br>t of Health and Mer<br>If Item 27 is marke<br>or other traumatic                                                                                    |                | 20a. Method of Disposition                                                                                                                                                                                                                                                                               |                                  |                                  |               | sition (Name of<br>matory or other place                        |                            | Date           |                    | 20c. Location - Ci         |                       | n State               |   |
| Baltimore, | permit. Pages of Department of Important: If Ite any injury or of once.                                                                                                   |                | Burial 2 ☐ Cremation 3                                                                                                                                                                                                                                                                                   |                                  | alle                             |               |                                                                 | - 1                        |                |                    |                            | •                     |                       |   |
| Ħ          | permit. Pag<br>Department<br>Important: II<br>any injury o                                                                                                                | 1              | 4 ☐ Donation 5 ☐ Other (Spe<br>21. Signature of Funeral Service W                                                                                                                                                                                                                                        | //                               | Ouan                             | tico          | National                                                        | Fe of Eacili               | eb. 22         | 2008               | Triangl                    | e. V                  | a                     |   |
| Ba         | perm<br>Depa<br>Impo<br>any i                                                                                                                                             |                | 21. Signature of Fulleral Service to                                                                                                                                                                                                                                                                     |                                  | 101085                           |               | 2. Name and Address 38 Marlbo                                   |                            |                |                    |                            |                       |                       |   |
|            |                                                                                                                                                                           |                | 23a Part Potor the diseases or of                                                                                                                                                                                                                                                                        | WW.                              |                                  |               |                                                                 |                            |                |                    |                            |                       |                       | - |
|            |                                                                                                                                                                           |                | 23a. Part. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)  a. Arteriosclerotic Cardiovascular Disease  Years |                                  |                                  |               |                                                                 |                            |                |                    |                            |                       |                       |   |
|            | Physician<br>/Medical                                                                                                                                                     |                | disease or condition resulting in death)                                                                                                                                                                                                                                                                 |                                  |                                  |               | ardiovasc                                                       | ular                       | Diseas         | 30                 |                            | Ye                    | ars                   | _ |
|            | Examiner                                                                                                                                                                  |                |                                                                                                                                                                                                                                                                                                          | Due to (or                       | as a conseque                    | nce of):      |                                                                 |                            |                |                    |                            |                       |                       |   |
| 80         |                                                                                                                                                                           | ia             | Sequentially list conditions,                                                                                                                                                                                                                                                                            | b. Due to (or                    | as a conseque                    | nce offic     |                                                                 |                            |                |                    |                            |                       |                       | _ |
|            | ted<br>nsit                                                                                                                                                               | Ē              | Sequentially list conditions, if any learning learning cause (Disease or injury that initiated events  Due to for as a consequence of cause (Disease or injury that initiated events  C.                                                                                                                 |                                  |                                  |               |                                                                 |                            |                |                    |                            |                       |                       |   |
| _6         | execu<br>al-tra                                                                                                                                                           | Examin         | resulting in death) Last                                                                                                                                                                                                                                                                                 | c<br>Due to (or                  | as a conseque                    | nce of):      |                                                                 |                            |                |                    |                            |                       |                       | - |
| 8760,      | cate be executed<br>bhysician and<br>the burial-transit                                                                                                                   | dical E        |                                                                                                                                                                                                                                                                                                          |                                  |                                  |               |                                                                 |                            |                |                    |                            |                       |                       |   |
| 289        | ficate<br>phy:<br>s the                                                                                                                                                   | bdic           |                                                                                                                                                                                                                                                                                                          | a                                |                                  |               |                                                                 |                            |                |                    |                            |                       |                       | _ |
| Box        | leath certifi<br>attending p                                                                                                                                              | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant                                                                                                                                                                                                                                                                 | 23c. If yes, outco               |                                  |               |                                                                 |                            |                |                    | 23d Date                   | 23d. Date of delivery |                       |   |
| m          | death<br>atte                                                                                                                                                             | cial           | in the past 12 months?<br>1 ☐ Yes 2 ☐ No                                                                                                                                                                                                                                                                 |                                  | th 2□Fetald<br>nt at time of dea |               | ]Ectopic pregnancy<br>] Other (specify)                         | 1                          |                |                    | Month                      |                       | Day Year              |   |
| P.0.       | at the de<br>by the                                                                                                                                                       | Jys            | 9 Unknown                                                                                                                                                                                                                                                                                                | 9□Unknow                         | /n                               |               |                                                                 |                            |                |                    |                            |                       |                       |   |
| о.<br>С    | The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as                                                       |                | Part II. Other significant condition                                                                                                                                                                                                                                                                     | s contributing to dea            | th but not resulti               | ing in the u  | nderlying cause giv                                             | en in Part I               | l.             | 23e. Did tob       | acco use contrib           | ute to the            | cause of death?       |   |
| Records,   | quire;<br>n sig<br>ald be                                                                                                                                                 | d by           | Anoxic Encephalo                                                                                                                                                                                                                                                                                         | mvelonath                        | v                                |               |                                                                 |                            |                | 1 □ Ye             | es 2⊡No 3                  | ☐ Proba               | bly 4X□Unknown        |   |
| 00         | w require<br>been si<br>should b                                                                                                                                          | lete           |                                                                                                                                                                                                                                                                                                          | , •1•pa <b>•</b>                 | ,                                |               |                                                                 |                            |                | 24a. Was ar        | 24b. We                    | ere auton             | sy findings available | _ |
| Be         | The lay                                                                                                                                                                   | Completed      |                                                                                                                                                                                                                                                                                                          |                                  |                                  |               |                                                                 |                            |                | autops<br>perform  | y prid<br>ned? dea         | or to com<br>ath?     | pletion of cause of   |   |
| Vital      |                                                                                                                                                                           |                | 25. Was case referred to medical                                                                                                                                                                                                                                                                         | 1                                |                                  |               |                                                                 | 06 Plan                    | ( D 1 / O      |                    |                            | Yes 2                 | No No                 | _ |
| 5          |                                                                                                                                                                           | o Be           | examiner?<br>1 ☐ Yes 新文No                                                                                                                                                                                                                                                                                | Hospital:                        | nationt 2 🗆 El                   | R/Outpatier   | nt 3 DOA Oth                                                    | er.                        | e of Death (C  |                    | ence 6 □Other              | (0:6                  |                       | _ |
| ō          | Physer this eral di                                                                                                                                                       |                | 27. Manner of Death                                                                                                                                                                                                                                                                                      | 28a. Date of                     | Injury 2                         | 8b. Time o    |                                                                 |                            |                |                    | w injury occurred          | . ,                   |                       |   |
| Division   | nding I<br>th.<br>: After<br>s funer                                                                                                                                      | ţi             | Natural 5 ☐ Pending<br>2 ☐ Accident investiga                                                                                                                                                                                                                                                            |                                  | Day Year)                        | Injury        |                                                                 | k?<br>Yes 2□               |                |                    |                            |                       |                       |   |
| /iSi       | Atter<br>r dea<br>ector                                                                                                                                                   | fica           | 3 Suicide 6 □ Could no                                                                                                                                                                                                                                                                                   | ed 28e. Place of                 | f injury - At hom                | ie, farm, str | eet, factory, office                                            |                            | 28f.           | Location (St.      | reet and Number            | or Rural              | Route Number,         |   |
| Ö          | al or<br>after<br>I Dire                                                                                                                                                  | Certification: | 4 Homicide determin                                                                                                                                                                                                                                                                                      | building                         | g, etc. (Specify)                |               |                                                                 |                            |                | City or Town       | , State)                   |                       |                       |   |
|            | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune                                                |                | 29a. Certifier 1 Certifying                                                                                                                                                                                                                                                                              | Physician: To the b              | est of my knowl                  | edge, deat    | h occurred at the tir                                           | ne, date ar                | nd place, and  | due to the ca      | ause(s) and manr           | ner as sta            | ited.                 |   |
|            | n 24 i                                                                                                                                                                    | Medical        | (Check only 2 Medical E:<br>one)                                                                                                                                                                                                                                                                         | kaminer: On the bas<br>and manne | sis of examination<br>or stated. | on and/or in  | vestigation, in my o                                            | pinion, de                 | ath occurred a | at the time, d     | ate and place, an          | d due to              | the cause(s)          |   |
|            | To the within To the Comp                                                                                                                                                 | M              | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                    | /m                               |                                  |               | 29c. Licens                                                     | e number                   |                | 2                  | 9d. Date signed (          | Month, E              | ay, Year)             |   |
|            | _                                                                                                                                                                         |                | Maul                                                                                                                                                                                                                                                                                                     | lan Ve                           | Wa                               | ec. (         | D0185                                                           | 2                          |                | E.                 | bruary                     | 1 2                   | 2008                  |   |
| 7          | DO 6                                                                                                                                                                      | <b>)</b>       | 30. Name and address of person w                                                                                                                                                                                                                                                                         | ho completed cause               | of death (Item 2                 | 23a) (Type,   |                                                                 |                            |                | Į F C              | bruary                     | ٠,٠                   | 2000                  | _ |
|            |                                                                                                                                                                           | -              | Paul A. DeVore M                                                                                                                                                                                                                                                                                         | ·                                |                                  |               | ad Hyatts                                                       | ville                      | Marv1          | and 20             | 0781                       |                       |                       |   |
|            | Sta                                                                                                                                                                       | ate            | 31. Date filed (Month, Day, Year)                                                                                                                                                                                                                                                                        | 32. Reg                          | gistrar's Signatu                | re            | ,                                                               |                            |                |                    |                            |                       |                       | _ |
|            | Regist                                                                                                                                                                    | rar            | FEB 1 9 2008                                                                                                                                                                                                                                                                                             | Kenny !                          | K Sha                            | 160           |                                                                 |                            |                |                    |                            |                       |                       |   |

DHMH 17 Rev 1/2001

|                |                                                                                                                                                                                                                                                                                                 |                 | For<br>State<br>Registrar                                                | State of Ma                                                          | ryland /                               |                                       | tment of H<br>ificate of L             |                                          | -                            | giene<br>Reg. No.2             | 08                                | 06427                                              |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------|---------------------------------------|----------------------------------------|------------------------------------------|------------------------------|--------------------------------|-----------------------------------|----------------------------------------------------|
|                |                                                                                                                                                                                                                                                                                                 | Н               | Decedent's Name (First, Middle, Las                                      | t)                                                                   |                                        |                                       |                                        |                                          | 2. Date of De                | ath                            |                                   | 3. Time of Death                                   |
|                | Physicia<br>/Medic                                                                                                                                                                                                                                                                              |                 | CHARLES HENRY                                                            | FOUNTAL                                                              | N, SR.                                 |                                       |                                        |                                          | Feb.                         | Day<br>1 0                     | Year<br>2008                      | 1602 M                                             |
|                | Examin                                                                                                                                                                                                                                                                                          | 5000            | 4a. Facility Name (If not institution, give                              |                                                                      |                                        | _                                     |                                        | Location of Death                        |                              | 4c. Count                      | y of Death                        |                                                    |
|                |                                                                                                                                                                                                                                                                                                 |                 |                                                                          | Medical                                                              | Cent 4                                 |                                       |                                        | Usking                                   |                              |                                | amic                              |                                                    |
|                | Funeral                                                                                                                                                                                                                                                                                         |                 | 5. Social Security Number 6. S                                           | ex 7. Age<br>LM 2□F                                                  | (In yrs. last b                        | irthday)<br>Yrs.                      | If Under 1 Year<br>Months Days         | If Under 24 Hrs.<br>Hours Min.           | 8. Date of Bir<br>(Month, Da | ay, Year)                      | Cou                               | place (State or Foreign<br>intry)                  |
|                | Director                                                                                                                                                                                                                                                                                        |                 | 213-16-8138 Usual Residence of Decedent                                  |                                                                      | 89                                     |                                       |                                        |                                          | Jan. 13                      | , 1919                         | Mar                               | yland                                              |
|                | yland<br>now<br>at                                                                                                                                                                                                                                                                              |                 | 10a. State 10b. County                                                   |                                                                      | 10c. City, Tov                         | wn or Loca                            | ation                                  |                                          |                              |                                |                                   | 10d. Inside City Limits                            |
|                | a-fsh                                                                                                                                                                                                                                                                                           | ctor            | Maryland Wicomico                                                        |                                                                      | Salisbu                                | ıry                                   |                                        |                                          |                              |                                |                                   | 1 ☐ Yes 2 v No                                     |
|                | or 28                                                                                                                                                                                                                                                                                           | Dire            | 10e. Street and Number                                                   |                                                                      |                                        |                                       | 10f. Zip Code                          |                                          |                              | 10g. Citizen of                | What Cou                          | intry?                                             |
|                | ath w                                                                                                                                                                                                                                                                                           | Funeral Directo | 220 Coulbourne Mil                                                       |                                                                      |                                        | T40.144                               | 21804                                  |                                          |                              |                                | JSA<br>4. Race - American Indian, |                                                    |
|                | ter de<br>Items<br>ner n                                                                                                                                                                                                                                                                        | nue             | 11. Marital Status 1 □ Never Married 2 ☑ Married                         | 12. Was Decedent E<br>Armed Forces?<br>1 ☐ Yes 2X N                  |                                        | 13. VV                                | as Decedent of Hi<br>Yes, specify Cuba | spanic Origin? (Si<br>In, Mexican, Puert | o Rican, etc.)               | D- 14. Da                      | ack, White,                       |                                                    |
|                | 72 hours after death with the Maryland<br>natural", or Items 23a or 28a-f show<br>iteal Examiner must be notified at                                                                                                                                                                            | by F            | 3 Widowed 4 Divorced                                                     | If Yes, Give<br>Year or Dates:                                       |                                        | 11                                    | ☐ Yes 2X No                            | Specify:                                 |                              | Spec                           | ify:<br>Blad                      | ole                                                |
| Š              | 72 hou<br>natura<br>ical E                                                                                                                                                                                                                                                                      |                 | 15. Decedent's Ed<br>(Specify only highest gra                           | lucation                                                             | 16                                     | a. Decede                             | ent's Usual Occup-                     | ation                                    | kina                         | 16b. Kind of I                 |                                   |                                                    |
| 7              | within 7<br>iene.<br>than "r<br>the Med                                                                                                                                                                                                                                                         | Completed       | Elementary/Secondary (0-12)                                              | College (1-4or 5-                                                    | +)                                     | life. Di                              | O NOT use retired                      | furing most of wor<br>)                  | Kilig                        | ŀ                              | ation                             |                                                    |
| ч              | e filed will Hygier other th                                                                                                                                                                                                                                                                    | ပ္ပ             | 7th                                                                      |                                                                      | So                                     | hool                                  | Bus Con                                | tractor<br>18. Mother's Nan              | on /Firet Adiatelle          |                                |                                   | ounty Board                                        |
| מום            | ld be fil<br>lental H<br>ked otl<br>ic ever                                                                                                                                                                                                                                                     | Be              | 17. Father's Name (First, Middle, Last) Stanford                         |                                                                      | Fount                                  | ain                                   |                                        | Ceci                                     |                              |                                | <sub>une)</sub><br>Crisfi         | eld                                                |
| 5              | 2 should be<br>and Mental<br>is marked<br>raumatic ev                                                                                                                                                                                                                                           | ဥ               | 19a. Informant's Name/Relationship (                                     | Type. Print)                                                         |                                        |                                       | Address (Street a                      | and Number or Ru                         |                              |                                |                                   |                                                    |
| 2              | and 2 sealth ar                                                                                                                                                                                                                                                                                 |                 | Margaret E. Founta                                                       | ,                                                                    |                                        | _                                     | · ·                                    | e Mill RE                                |                              |                                |                                   |                                                    |
| ָרָ<br>בּ      | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                 | 20a. Method of Disposition                                               |                                                                      | 20b. Place                             | of Disposi                            | ition (Name of<br>atory or other place | i                                        | Date                         | 20c. Location                  |                                   |                                                    |
| 5              | Page<br>nent o<br>nt: If                                                                                                                                                                                                                                                                        |                 | 1 ፟ Burial 2 □ Cremation 3 □<br>4 □ Donation 5 □ Other ( <i>Specif</i>   |                                                                      |                                        | -                                     |                                        | · .                                      | /2008                        | Eruitla                        | nd M                              | laryland                                           |
| =<br>0         | mit. porta porta y inju                                                                                                                                                                                                                                                                         |                 | 21. Sign were if Funeral Service Licer                                   | isee                                                                 | /                                      | 22.                                   | Name and Addres                        | ss of Facility 12                        | 13 Jerse                     | ey Road,                       | Salis                             | laryland<br>sbury, MD                              |
| 0              | <b>63 = 5</b>                                                                                                                                                                                                                                                                                   |                 | Talrice                                                                  | a fall                                                               | ey                                     | _                                     |                                        | EMORIAL                                  |                              |                                | 2                                 | 21801                                              |
|                |                                                                                                                                                                                                                                                                                                 |                 | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused<br>one cause on each lin                      | the death. Do                          | o not ente                            | r the mode of dyin                     | g, such as cardiad                       | or respiratory a             | arrest,                        |                                   | Approximate<br>Interval Between<br>Onset and Death |
|                | Physician                                                                                                                                                                                                                                                                                       |                 | Immediate Cause (Final disease or condition resulting in death)          | a. RECM.                                                             | rto N                                  | 7 /                                   | +SPIRM                                 | MON,                                     | PNEUN                        | rows                           |                                   | WEEKS                                              |
|                | /Medical<br>Examiner                                                                                                                                                                                                                                                                            |                 | resulting in death)                                                      | Due to (or as                                                        | a consequence                          | e of):                                |                                        |                                          |                              |                                |                                   |                                                    |
|                |                                                                                                                                                                                                                                                                                                 | <u></u>         | Sequentially list conditions,                                            | b. Due to for as                                                     | a conse lueno                          | e of                                  |                                        |                                          |                              |                                | -                                 |                                                    |
|                | nted<br>Insit                                                                                                                                                                                                                                                                                   | Examiner        | cause. Enter Underlying Cause (Disease or injury                         |                                                                      | ************************************** |                                       |                                        |                                          |                              |                                |                                   |                                                    |
| ,              | execu<br>in and<br>ial-tra                                                                                                                                                                                                                                                                      | Exa             | that initiated events<br>resulting in death) Last                        | CDue to (or as a                                                     | a consequenc                           | e of):                                |                                        |                                          |                              |                                |                                   |                                                    |
| 00/00          | ficate be executed<br>physician and<br>sthe burial-transit                                                                                                                                                                                                                                      | edical          |                                                                          | ⊷d                                                                   |                                        |                                       |                                        | E 1 111 E                                |                              |                                |                                   |                                                    |
|                | rtifica<br>ng ph<br>as th                                                                                                                                                                                                                                                                       |                 | IE ECHALC.                                                               |                                                                      |                                        |                                       |                                        |                                          |                              |                                |                                   |                                                    |
| DOX<br>DOX     | The law requires that the death certificate be executed the has been signed by the attending physician and tayes 2 should be detached for use as the burial-transit                                                                                                                             | Physician/M     | IF FEMALE: 23b. Was decedent pregnant                                    | 23c. If yes, outcome 1 ☐ Live birth                                  |                                        | 23d. Date of delivery  Month Day Year |                                        |                                          |                              |                                |                                   |                                                    |
|                | e dea<br>the at<br>red fo                                                                                                                                                                                                                                                                       | sici            | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                  | 4□Pregnant at<br>9□Unknown                                           | time of death                          | 5 🗌                                   | Other (specify) _                      |                                          |                              |                                | nontri                            | Day Teal                                           |
| Ŀ              | hat the                                                                                                                                                                                                                                                                                         |                 | Part II. Other significant conditions                                    | contributing to death bu                                             | ut not resulting                       | in the un                             | derlying cause giv                     | en in Part I.                            | 23e. Did                     | tobacco use co                 | ntribute to                       | the cause of death?                                |
| vital Records, | w requires that the di<br>been signed by the<br>should be detached                                                                                                                                                                                                                              | l by            | CE REBROVA.                                                              |                                                                      |                                        |                                       |                                        |                                          |                              |                                |                                   | obably 4 Unknown                                   |
| 5              | v requ                                                                                                                                                                                                                                                                                          | Completed       | PARKINSON'S                                                              |                                                                      |                                        |                                       |                                        |                                          | 24a. Was                     | e an   24t                     | . Ware au                         | topsy findings available                           |
| Į.             | The lay<br>ate has<br>page 2                                                                                                                                                                                                                                                                    | ш               | 77.1117103070                                                            | - // - //                                                            | 75                                     |                                       |                                        |                                          | auto<br>perf                 | opsy<br>formed?                | prior to c death?                 | completion of cause of                             |
| D.             |                                                                                                                                                                                                                                                                                                 |                 | 25. Was case referred to medical                                         |                                                                      |                                        |                                       |                                        | 26. Place of Dea                         | 1 Yes                        |                                | 1 □ Yes                           | 2□ No                                              |
| >              | yslci<br>is cer<br>direct                                                                                                                                                                                                                                                                       | o Be            | examiner?<br>1 ☐ Yes 2 ☑ No                                              | Hospital:                                                            | ent 2 ☐ ER/0                           | Outpatient                            | 3□ DOA Oth                             | or:                                      | dome 5 ☐ Res                 |                                | ther (Spec                        | cífy)                                              |
| 0              | ig Ph<br>ter th                                                                                                                                                                                                                                                                                 | T :U            | 27. Manner of Death 1 ☑ Matural 5 ☐ Pending                              | 28a. Date of Inju<br>(Month, Day                                     |                                        | o. Time of<br>Injury                  | 28c. Injur<br>Wor                      |                                          |                              | how injury occ                 |                                   | ,                                                  |
| 0              | endlr<br>ath.<br>or; Af<br>he fu                                                                                                                                                                                                                                                                | atio            | 2 Accident investigation                                                 | 1                                                                    |                                        |                                       |                                        | Yes 2 □ No                               |                              |                                |                                   |                                                    |
| DIVISION       | pr Att<br>ter de<br>lirect                                                                                                                                                                                                                                                                      | Certification:  | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined                   | 28e. Place of inju-<br>building, etc                                 |                                        | farm, stre                            | et, factory, office                    |                                          |                              | (Street and Nur<br>own, State) | nber or Ru                        | iral Route Number,                                 |
|                | pital of urs all saral Differing                                                                                                                                                                                                                                                                |                 | Con Continue 15 Continue Di                                              | il                                                                   | of my knowled                          | lan donth                             | accurred at the ti                     | ma data and plac                         |                              |                                |                                   | -t-t-d                                             |
|                | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,                                                                                                                               | Medical         |                                                                          | nysician: To the best of<br>miner: On the basis of<br>and manner sta | f examination                          |                                       |                                        |                                          |                              |                                |                                   |                                                    |
|                | o the                                                                                                                                                                                                                                                                                           | Mec             | 29b. Signature and title of certifier                                    | and manner ste                                                       |                                        |                                       | 29c. Licens                            | e number                                 |                              | 29d. Date sig                  | ned (Monti                        | h, Day, Year)                                      |
| )              | - s - ō                                                                                                                                                                                                                                                                                         |                 | ) / _                                                                    |                                                                      | MO                                     |                                       | 0.                                     | 006291                                   | 6                            | FEBR                           | MAR.                              | 11,2008                                            |
|                | LIM                                                                                                                                                                                                                                                                                             |                 | 30. Name and address of person who                                       | completed cause of d                                                 | eath (Item 23a                         | a) (Type, F                           | Print)                                 |                                          |                              |                                |                                   |                                                    |
|                | 1                                                                                                                                                                                                                                                                                               |                 | SVETZANA GIA                                                             | Jennez 1                                                             | 1415 5                                 | our                                   | 7+ 8101                                | SIAN SU                                  | ITEB                         | SALS                           | 342                               | 2000 21804                                         |
|                | Sta                                                                                                                                                                                                                                                                                             |                 | 31. Date filed (Month, Day, Year)                                        | 32. Fugistr                                                          | ar's Signature                         | , /                                   | and a                                  |                                          |                              |                                |                                   |                                                    |
|                | Regist                                                                                                                                                                                                                                                                                          | rar             | FEB 14 2                                                                 | UUO OUU                                                              | ACO SIS                                | AND CALL                              | The same of the same                   |                                          |                              |                                |                                   |                                                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Date of Death **Physician** Mont Year U556 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Jan 3, 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Funeral Months 1 XM 2 ☐ F Director 213 26 2077 79 1929 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If them 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f sh notifled 1 ☐ Yes 2 No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be r 3832 Old Columbia Pike 21043 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 ☐ No If Yes, Give Year or Dates: 1951–53 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Auditor Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be R. Russell Grimes Rose Tilling or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma K. Grimes/Wife 3832 Old Columbia Pike Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cem. 2-19-2008 Ellicott City, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01044 Harry H. Witzke's Family FH Inc. - Well ~~ 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MADDO disease or condition resulting in death) aro 20 1005 /Medical Due to (or as a conseq ence of) Examiner ia OUF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p for use as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho autopsy page ; performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No ပ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: within 24 hours a

22

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (0 31. Date filed (Month, Day,

2008

FEB 19

32. Fegistrar's Signature

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Registrar

Medical

(Check only one)

|                                                                                                                                            |                   |                                                                                           |                                         |                            | Indelible Ink                                     |                                |                                 | Are Legible.                            |                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------|---------------------------------------------------|--------------------------------|---------------------------------|-----------------------------------------|------------------------------------------------|
|                                                                                                                                            |                   | For State Registrar                                                                       | ile of Mary                             |                            | epartificate of                                   |                                | -                               | giene<br>Reg. No. 2008                  | 06629                                          |
| Division                                                                                                                                   |                   | Decedent's Name (First, Middle, Last)                                                     |                                         |                            |                                                   |                                | 2. Date of De                   | ath                                     | 3. Time of Death                               |
| Physicia /Medica                                                                                                                           | _                 | Anita Thrift Greenwe                                                                      |                                         |                            |                                                   |                                | FEBRU                           | ARY 12, 2008                            | M A21:8                                        |
| Examine                                                                                                                                    | r                 | 4a. Facility Name (If not institution, give street:  CIVISTA MEDICAL                      | CEUT                                    | =12                        | 4b. City, Town, o                                 | Pr Location of Death           |                                 | 4c. County of Death                     |                                                |
| Funeral                                                                                                                                    | . *               | Social Security Number 6. Sex                                                             | 7. Age (/                               | n yrs. last birth          | day) If Under 1 Year<br>Months Days               | If Under 24 Hrs. Hours Min.    | 8. Date of Birt<br>(Month, Da   | th 9 Birth                              | nnlace (State or Foreign                       |
| Director                                                                                                                                   |                   | 219-34-8103 1□ M 2 Usual Residence of Decedent                                            | 72                                      | 2 Yı                       | rs. Months Days                                   | Hours Min.                     | Dec. 1                          | 4, 1935 Mary                            | /land                                          |
| yland<br>now<br>at                                                                                                                         |                   | 10a. State 10b. County                                                                    | 10                                      | Oc. City, Town             | or Location                                       |                                |                                 |                                         | 10d. Inside City Limits                        |
| ne Mar<br>8a-f sh<br>stifled                                                                                                               | Director          | Maryland Charles                                                                          |                                         | Waldorf                    | -                                                 |                                |                                 |                                         | 1X Yes 2 No                                    |
|                                                                                                                                            |                   | 10e. Street and Number                                                                    |                                         |                            | 10f. Zip Code                                     |                                |                                 | 10g. Citizen of What Cou                | untry?                                         |
| ter death<br>Items 23<br>Iner musi                                                                                                         | runeral           | P.O. Box 186                                                                              | s Decedent Eve                          | er in U.S.                 | 13. Was Decedent of H<br>If Yes, specify Cub      | Hispanic Origin? (Sp           | ecify Yes or No                 | USA<br>14. Race - Amer                  |                                                |
| after<br>or Ite                                                                                                                            |                   | 1 ☐ Never Married 2 ☐ Married 1 ☐                                                         | ned Forces?<br>]Yes 2 X No<br>'es, Give |                            | If Yes, specify Cub  1 ☐ Yes 2 No                 | an, Mexican, Puerto  Specify:  | Rican, etc.)                    | Black, White<br>Specify: Wh             |                                                |
| hours<br>tural";                                                                                                                           | ed by             | 3 ☐ Widowed 4 ☐ Divorced Ÿe                                                               | ar or Dates:                            | 160 [                      | ecedent's Usual Occur                             |                                |                                 |                                         |                                                |
| be filed within 72 ho tal Hygiene. d other than "natul event, the M-di-al                                                                  | Сотріете          | (Specify only highest grade com                                                           | oleted)<br>llege (1-4or 5+)             |                            | Give kind of work done<br>life. DO NOT use retire | during most of work<br>d)      | ing                             | 16b. Kind of Business/li                | noustry                                        |
| ed with<br>ygiene<br>ygiene<br>rtha<br>t, the                                                                                              | E .               | 12                                                                                        | 4                                       |                            | Home Make                                         | r                              |                                 | Own Home                                |                                                |
| e d la be                                                                                                                                  | De De             | 17. Father's Name (First, Middle, Last)                                                   |                                         |                            |                                                   |                                | , , , , , ,                     | , Maiden Surname)                       |                                                |
| d 2 should be filed within the and Mental Hygiene. T Is marked other than traumatic event, the Mental Hygiene.                             | <u> </u>          | Maurice Thrift  19a. Informant's Name/Relationship (Type. Pr.                             | int)                                    | 19b. N                     | Mailing Address (Street                           | Anita Car<br>and Number or Run |                                 | Thrift<br>er, City or Town, State, Z    | ip Code)                                       |
| and 2 salth a n 27 is                                                                                                                      |                   | Susan Parks / Daug                                                                        | hter                                    |                            | O. Box 186 Disposition (Name of                   |                                |                                 |                                         | ,,                                             |
| permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other train                                            |                   | 20a. Method of Disposition  1/□X Burial 2 □ Cremation 3 □ Remove                          | I from State                            | cemetery,                  | crematory or other pla                            | ce)                            |                                 |                                         |                                                |
| iit. Pa<br>artmen<br>ortant:<br>Injury                                                                                                     |                   | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee               |                                         | Our Lad                    | y's Church                                        | Cem. Feb.                      | 15,200                          | 8 Leonardto                             | wn, Maryland                                   |
| permi<br>Depar<br>Impon<br>any Ir                                                                                                          | 1                 |                                                                                           | 29210                                   |                            | 22. Name and Addre                                |                                |                                 | ral Home<br>aldorf, MD.                 | 20601                                          |
|                                                                                                                                            | 1                 | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau | s that caused the                       | e death. Do no             |                                                   |                                |                                 |                                         | Approximate<br>Interval Between                |
| Physician                                                                                                                                  | 1                 | Immediate Cause (Final disease or condition resulting in death)                           | 95ch                                    | emre                       | - Con                                             | to myo                         | pathy                           | /                                       | Onset and Death                                |
| /Medical<br>Examiner                                                                                                                       |                   | resulting in death)                                                                       | Ou to (or as a co                       | onsequence of              | 1 1 1 1                                           | fred free                      | - 11                            | 0                                       | /                                              |
| LE RE                                                                                                                                      | Jer               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying        | Oue to (or as a co                      | onsequence of              | 0657                                              | preg                           | - Just                          | enough                                  |                                                |
| be executed<br>dian and<br>nurial-fransit                                                                                                  | Examiner          | Cause (Disease or injury that initiated events resulting in death) Last                   |                                         |                            | 101                                               | igence                         |                                 |                                         |                                                |
| be exe                                                                                                                                     | - 1               | resulting in death) cast                                                                  | Due to (or as a co                      | onsequence of              | :                                                 |                                |                                 |                                         |                                                |
| The law requires that the death certificate be take has been signed by the attending physicianage 2 should be detached for use as the burn | Physician/Imedica | d                                                                                         |                                         |                            |                                                   |                                | -                               |                                         |                                                |
| eath cert<br>attending<br>for use a                                                                                                        | MI/IM             | 23b. Was decedent pregnant                                                                | es, outcome pf p                        |                            | 3 ☐Ectopic pregnanc                               |                                |                                 | 23d. Date of deli                       | very                                           |
| ne dea<br>the att                                                                                                                          | SICI              | 1 Ves 2 No. 4                                                                             | Pregnant at tim                         |                            | 5 Other (specify)                                 | <u> </u>                       |                                 | Month                                   | Day Year                                       |
| uires that the de                                                                                                                          |                   | Part II. Other significant conditions contributi                                          | ng to death but n                       | ot resulting in t          | he underlying cause giv                           | en in Part I.                  | 23e. Did t                      | obacco use contribute to                | the cause of death?                            |
| quires<br>in sign<br>uld be                                                                                                                | a by              |                                                                                           |                                         |                            | 112                                               | /                              | obably 4 ∐Unknown               |                                         |                                                |
| e law requir<br>has been si<br>je 2 should                                                                                                 | Completed         |                                                                                           |                                         |                            |                                                   |                                | 24a. Was                        | an / 24b. Were au                       | topsy findings available ompletion of cause of |
|                                                                                                                                            | E 0               |                                                                                           |                                         |                            |                                                   |                                | perfo                           | ormed7   death?                         | 2 No                                           |
| G G G                                                                                                                                      | o De              | 25. Was case referred to medical examiner?  1 Yes 2 No Hospita                            | I A A L                                 |                            | ationt 3 DOA Oth                                  | 26. Place of Deat              |                                 |                                         |                                                |
| ding Phys                                                                                                                                  | - 1               | 27. M n er of Death 28a                                                                   | Date of Injury (Month, Day Yo           | 2 ER/Outp                  | ne of 28c. Injur                                  | 4 ∐ Nursing Ho                 |                                 | dence 6 Other (Specthow injury occurred | eify)                                          |
| Attending r death. ector: After                                                                                                            | Satio             | 1  Natural 5  Pending 2  Accident investigation 3  Suicide 6  Codd not be                 | (World), Day 11                         | ear) Inji                  |                                                   | Yes 2 □ No                     |                                 |                                         |                                                |
| To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the ti                 | Ceruncation:      | 3 Suicide 6 Codid not be<br>4 Homicide determined 28€                                     | Place of injury building, etc. (        | - At home, fam<br>Specify) | i, street, factory, office                        |                                | 28f. Location (S<br>City or Tox | Street and Number or Ru<br>wn, State)   | ral Route Number,                              |
| spital<br>nours and meral                                                                                                                  |                   | 29a. Certifier 1 Certifying Physician:                                                    | To the best of m                        | ny knowledge,              | death occurred at the ti                          | me, date and place,            | and due to the                  | cause(s) and manner as                  | stated.                                        |
| the Ho<br>nin 24 I<br>the Fu<br>upletel                                                                                                    | Medical           | one) 2 Medical Examiner: O                                                                | n the basis of ex<br>ad manner stated   | amination and/             | or investigation, in my                           | opinion, death occur           | red at the time,                | date and place, and due                 | to the cause(s)                                |
| To To Con                                                                                                                                  | 2                 | 29b. Signature and title of certifier                                                     | 12-                                     |                            | 29c. Licens                                       | se number                      | $\sim$                          | 29d. Date signed (Month                 | n, Day, Year)                                  |
|                                                                                                                                            |                   | 39 Name and address of person who complete                                                | ad cause of doct                        | 1 (Item 22a) (T            | Una Print)                                        | 5/1/14                         |                                 | 0/12/                                   | rois                                           |
| 685                                                                                                                                        | *                 | Straine and address of person who complete                                                | I MiD.                                  | 1 Up                       | ype, Print)                                       | e Road                         | , we                            | ldorf, 4                                | 10, 20602                                      |
| State                                                                                                                                      |                   | 31. Date filed (Month, Day, Year)                                                         | 32. Registrar's                         | Signature                  | - V-6                                             |                                |                                 | 0                                       |                                                |
| Registra                                                                                                                                   |                   | FEB 1 5 2008                                                                              | MIA /                                   | F April                    | W.                                                |                                |                                 |                                         |                                                |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Anita Millicent Hazell Feb. 2008 12:07 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rockville 4c. County of Death Examiner Shady Grove Seventh Day Adventist Hospital Montgomery County If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral**  Birthplace (State or Foreign Country) Days 1 M 2 K 63 Director May 27 1944 New York 081-34-2867 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐Yes 2 No Directo Washington County Hagerstown Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 19902 Hayfield Court 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forcee? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Food & Beverage Elementary/Secondary (0-12) College (1-4or 5+) Owner Distributor 7 is marked other traumatic event, if 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William D. Felder Eva Mae Mitchell Felder ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14379 Berkshire Dr. Woodbridge, VA 22193 Item 27 other to Monica L. Mitchell-daughter

20a. Method of Disposition

1 M Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department or Important: If I any Injury or once, = 5 2-15-2008 Beaver Creek Cemetery Beaver Creek, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) pneumonia days /Medical Di to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy 1 ☐ Yes 2 No 1□ Yes 2K No Be 25. Was case referred to medical funeral director 26. Place of Death Check onl one examiner? 2 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Impatient 2 ER/Outpatient 3 DOA After this 27. Manner of eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day Year) Votre nous after death.

Vithin 24 hours after death.

To the Funeral Director: Af investigation M 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Februar 12,2008 PS 4738 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH-4 9901 Medical Center Dr. Rockvill, MD 20850 Alicia Mistry

State Registrar

DHMH 17 Rev 1/2001

FEB 1 9 2008

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 12, 2008 **Physician** Kathleen Μ. Harden 6:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, August 1, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 1□M 2 F Davs Hours 80 577-32-5176 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2XXNo Director Prince George's Temple Hills Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3422 24th Avenue 20748 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐ Yes 2,7∑1 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Supervisor Program Management Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Owen Margaret Creamer Canty ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Harden / Son 5615 Belleau Woods Lane Alexandria, Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 Removal from State 02/18/2008 Resurrection Cemetery Clinton, Maryland √5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of Funeral Service Licensee alas 6160 Oxon Hill Road Oxon Hill, Maryland Approximate Interval Between Onset and Death 23a. Farri. Enter the disease, 'r complications shock, or heart failure. List only one cause aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** truephalop THOXIC /Medical Due to (or as a consequence of) Examiner Renal Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Respirator signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 1 □ Yes After this certificate 2□ No 2 No the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 1 ☑Natural 28b. Time of 28d. Describe how injury occurred (Month, Day or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Funerai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) within 2. and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARZAD MaleKanian mo 7503 Surratts RD Clinton, md 20735 31. Date filed (Month, Day, Year) 2008 Registrar

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

**ORIGINAL** 

ANNE ARUNDEL MEDICAL CENTER, 2001 MEDICAL PARKWAY, ANNAPOLIS, MD

30. Name and address of puren who completed cause of death (Item 23a) (Type, Print)

200B

32. Registrar's Signature

M.D.,

AMIEE YU 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5, 10e, 19b per fh 8878 4-15-08 vt. State of Maryland 7 Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day <u>5:1</u>5 <sup>A</sup> м Physician Kermit A. Hooper Feb. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis of La Plata

5. Social Securit 0825 6. Sex Plata Charles La If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**XM 2□F Yrs. 83 007-16-0827 Director Oct. 18, 1924 | Maine Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1∩a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director Charles Marvland Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Trumpeter Trumpter Court 20601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married An Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/XNo Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) g Metropolitan Police District of Columbia 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Walter Myron Hooper Amelia Vesta Scammons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Trumpeter 19a. Informant's Name/Relationship (Type. Print) Trumpter Court, Waldorf, Maryland, 20601 <u>Geraldine Ruth Hooper</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet's. Cem. Feb. 26, 2008 Cheltenham, MD 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Servi Mu 3035 Old Washington Rd. Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car/ ia. or respiratory arrest, shock, or heart failure. List only one car is each line. EVEVALMONARU Immediate Cause (Final disease or condition resulting in death) BSTRuct MONIC Physician /Medical Due to (or as a consequence of) Examiner word VI was U Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown סמופי nas been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy certificate Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident 24 hours after death Puneral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2. To the I 290 License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier on who completed cause of death (Item 23e) (Type, Print) te and address of per BUR 31. Date filed (Month, Day, Year) 2008 15 Registrar FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AM **Physician** February 10, 2008 9:15 Benton Roy Hanan, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Waldorf If Under 1 Year Morningside House Charles If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Oklahoma 1 X M 2 ☐ F July 6, 1915 92 Director 233-52-8619 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at XXYes 2 □ No Director Waldorf Maryland Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ir than "natural", or items 23a the Medical Examiner must b 20602 USA 70 Village Street, # 213 by Funeral - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clergy Minister permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie.
Important: If Item 27 is marked other It
any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Brown Hanan ဂ္ Benton Roy Hanan, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15120 Nelson Perrie Rd. Brandywine, Maryland, 20613 Kim Richards/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 13, 2008 Waldorf, Maryland **Huntt Crematory** 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Serice Licens 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Concel one **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy ial or Attending Physician: The safter death.

In Director: After this certificate of in by the funeral director, pared in by the funeral director, pared in by the funeral director, pared in by the funeral director, pared in by the funeral director, pared in by the funeral director, pared in by the funeral director, pared in by the funeral director, pared in by the funeral director, pared in by the funeral director, pared in by the funeral director, pared in the funeral director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director and director an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 200 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funeral L the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Commedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registrar

0

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 1 5 2008

70

32. Registrar's Signature

|               |                                                                                                                                                                          |                   | for<br>State<br>Registra AMEND#18per                                                                                                                                                                                                                      | State of TNF2/25/08.                             | of Marylar                                                                                                                                                                                                                    | nd / Depa                                  | artmen<br>rtificat                     |                                  |                            |                        |                                   | giene<br>Rea. No     | 2002                                            | 06436                                                    |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------|----------------------------------|----------------------------|------------------------|-----------------------------------|----------------------|-------------------------------------------------|----------------------------------------------------------|
|               | Physici<br>/Medi                                                                                                                                                         |                   | 1. Decedent's Name (First, Middle Clara Ada                                                                                                                                                                                                               | e, Last)                                         |                                                                                                                                                                                                                               |                                            |                                        |                                  |                            |                        | 2. Date of Dea<br>Month<br>Februa | ath<br>Da            | y Year                                          | 3. Time of Death 4:05a                                   |
|               | Examir<br>Funeral<br>Director                                                                                                                                            |                   | 4a. Facility Name (If not institution 3557 South Le 5. Social Security Number                                                                                                                                                                             |                                                  | rld Blvd<br>7. Age (In yrs.                                                                                                                                                                                                   |                                            |                                        |                                  | Location of Silve If Under | r Sp                   | ring  8. Date of Birt (Month, Da) | h<br>y, Year         | Mon tgom  9. Birthp Country of Death            | nery<br>lace (State or Foreign                           |
|               | D                                                                                                                                                                        | tor               | 577-38-4242  Usual Residence of Decedent  10a. State  10b. County  Maryland                                                                                                                                                                               | Montgom                                          |                                                                                                                                                                                                                               | ty, Town or Lo                             |                                        | C-n-s-i-n                        |                            |                        | May 19                            | , 1                  |                                                 | egia<br>Od. Inside City Limits<br>1 □ Yes 2 □ No         |
|               | ath with the<br>s 23a or 28a<br>just be noth                                                                                                                             | ral Director      | 10e. Street and Number 3557 South Le                                                                                                                                                                                                                      | sure Wor                                         | ld Blvd                                                                                                                                                                                                                       | ., #1F                                     | lver<br>10f. Zip                       | Code                             | 2090                       |                        |                                   |                      | tizen of What Coun                              |                                                          |
| -0036         | be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | ed by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Marr  3 □ Widowed 4 □ Divorced                                                                                                                                                                                  | ied Armed F<br>1   Yes<br>If Yes, G<br>Year or I | ₩ No<br>live                                                                                                                                                                                                                  |                                            | 1□ Yes                                 | 2 <mark>⊋</mark> No              | Specify:                   | gin? (Spe<br>i, Puerto | cify Yes or No-<br>Rican, etc.)   |                      | 14. Race - Americ<br>Black, White,<br>SpedMhite | etc.                                                     |
| 121215-0036   | filed within 72<br>Hygiene.<br>rther than "na<br>rth, the Medic                                                                                                          | Completed         | 15. Deceden (Specify only highe) Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle,                                                                                                                                                        | St grade completed<br>College                    | (1-4or 5+)                                                                                                                                                                                                                    | (Give                                      | dent's Usu:<br>kind of wo<br>DO NOT u: | rk done d<br>se retired<br>stral | during mosi<br>)<br>cive   | Offi                   | cer                               |                      | FAA                                             | dustry                                                   |
| Maryland      | 2 should be f<br>and Mental H<br>Is marked of<br>raumatic eve                                                                                                            | To Be             | Charles Wright  19a. Informant's Name/Relations                                                                                                                                                                                                           | Adams                                            | <del></del>                                                                                                                                                                                                                   | 19b. Maili                                 | ng Address                             |                                  |                            |                        | (First, Middle,                   |                      | gan  or Town, State, Zip                        | Code)                                                    |
| Baltimore, Ma | es 1 and 2<br>of Health<br>Item 27 is<br>other tra                                                                                                                       |                   | Noreen T. Hann 20a. Method of Disposition  PS Burial 2 □ Cremation 4 □ Donation 5 □ Other (S                                                                                                                                                              | 3 □Removal from                                  | 20b.                                                                                                                                                                                                                          | Place of Dispo<br>cemetery, cre<br>lingtor | esition (Nar<br>matory or c<br>Nat:    | ne of<br>other plac<br>iona      | e) .                       | Feb.                   | 14,                               | 20c. L               | ocation - City or To                            |                                                          |
| Ball          | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once,                                                                                                 |                   | 21. Signature of Funeral Service  William L  23a. Part1. Enter the disease, or                                                                                                                                                                            | Liles                                            |                                                                                                                                                                                                                               | I<br>I                                     | 2. Name ar<br>Tranci<br>500 Ur         | iivei                            | sity                       | lins<br>Blv            | Funera<br>d. W. S                 | l Ho<br>ilve         | ome Inc.                                        | , MD 20901                                               |
| 8760,         | Physician /Medical Examiner and the prujal-transit                                                                                                                       | dical Examiner    | shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that intitated events resulting in death) Last | a. E:  Due to  Due to                            | each line.  Sophage a lor (or as a consect of (or as a consect of (or as a consect of (or as a consect of (or as a consect of (or as a consect of (or as a consect of (or as a consect of (or as a consect of (or as a consec | al Cano                                    |                                        |                                  | 9, 040/140                 | our diac o             | Topindory an                      |                      |                                                 | Approximate Interval Between Onset and Death             |
| O. Box 6      | the death certifi<br>y the attending<br>ched for use as                                                                                                                  | Physician/Med     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                                                                                                                                                   | 1 ☐Live                                          | utcome pf pregn<br>birth 2 □ Feta<br>gnant at time of c<br>nown                                                                                                                                                               | al death 3                                 | Ectopic pr                             |                                  |                            |                        |                                   |                      | 23d. Date of delive<br>Month                    | ery<br>Day Year                                          |
| Records, P.   | The law requires that the de<br>ate has been signed by the a<br>page 2 should be detached t                                                                              | by                | Part II. Other significant condition                                                                                                                                                                                                                      | ons contributing to                              | death but not res                                                                                                                                                                                                             | sulting in the u                           | nderlying c                            | ause give                        | en in Part I.              |                        | 101                               | es 2                 |                                                 | ably 4 ☑Unknown                                          |
| Vital Re      |                                                                                                                                                                          | Be Completed      | 25. Was case referred to medical examiner?                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                                               |                                            |                                        |                                  |                            | of Death               | 24a. Was autop perfo              | nsy<br>rmed?<br>2 No | prior to cor<br>death?                          | psy findings available<br>npletion of cause of<br>2 ☐ No |
| 9             | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,          | Certification: To | 27. Manner of Death  1 Natural 2 Accident 3 Suicide  5 Pendin investig                                                                                                                                                                                    | g 28a. Date (Moi                                 | Inpatient 2 of Injury nth, Day Year)                                                                                                                                                                                          | 28b. Time o<br>Injury                      | f 2                                    | 8c. Injury<br>Work<br>1 🗆 `      | 4 LI NU                    | No 2                   | 28d. Describe h                   | iow inju             | 6 □Other (Specify occurred on Number or Rura    |                                                          |
| D.            | Hospital or /<br>24 hours after<br>Funeral Dire                                                                                                                          |                   | 4 Homicide determ  29a. Certifier tCkCertifyin (Check only 2 Medical                                                                                                                                                                                      | g Physiclan: To th                               | ding, etc. (Speci                                                                                                                                                                                                             | owledge, deat                              | h occurred                             | at the tim                       | ne, date an                | d place a              | City or Tow                       | rn, State            | e)                                              | tatad                                                    |
|               | To the H within 24 To the Fi complete                                                                                                                                    | Medical           | 29b. Signature and title of certifie                                                                                                                                                                                                                      | w W                                              | in all                                                                                                                                                                                                                        | Perst                                      | 290                                    | c. License                       | number<br>D646             | 15                     |                                   | 29d. Da<br>Febi      | ate signed (Month, ruary 13,                    | Day, Year)<br>2008                                       |
| 2             | Sta<br>Registr                                                                                                                                                           |                   | 30. Name and address of person r Genevieve Wr  31. Date filed (Month, Day, Year)                                                                                                                                                                          |                                                  | MD 60                                                                                                                                                                                                                         |                                            | caste                                  |                                  | 11 R                       | oad,                   | Rockvi                            | lle                  | , MD 2085                                       | 5                                                        |

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|            |                                                                                                                                               |                  | 1 - For<br>State<br>Registrar                                                                                                  | State of M                                                  | laryland / I                    | Depa<br><i>Cer</i> | rtment of F                                                  | lealth<br><i>Death</i>           | and Me                        |                                               | jiene ()                    | 08                             | 06438                                        |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------|--------------------|--------------------------------------------------------------|----------------------------------|-------------------------------|-----------------------------------------------|-----------------------------|--------------------------------|----------------------------------------------|
|            |                                                                                                                                               |                  | 1. Decedent's Name (First, Middle, Last                                                                                        |                                                             |                                 |                    |                                                              |                                  | 1                             | 2. Date of Dea<br>Month                       |                             | V                              | 3. Time of Death                             |
|            | Physici<br>/Medi                                                                                                                              |                  | BARBARA                                                                                                                        | MAE                                                         | HAI                             | L                  |                                                              |                                  | F                             |                                               |                             | 0 0 8                          | 8:00A M                                      |
|            | Examir                                                                                                                                        |                  | 4a. Facility Name (If not institution, give                                                                                    | street and number                                           | )                               |                    | 4b. City, Town, o                                            | r Location                       | of Death                      | •                                             | 4c. Cou                     | inty of Death                  |                                              |
|            |                                                                                                                                               |                  | Manor Care of :                                                                                                                |                                                             |                                 |                    | Bethe                                                        |                                  | - 0.4.1.                      |                                               | Mor                         | ntgome                         |                                              |
|            | Funeral<br>Director                                                                                                                           |                  |                                                                                                                                | x                                                           | ge (In yrs. last bii            | rthday)<br>Yrs.    | Months Days                                                  | Hours                            |                               | B. Date of Birth<br>(Month, Day)<br>(1ar . 23 |                             | M - COUL                       | lace (State or Foreign                       |
|            | and *                                                                                                                                         |                  | Usual Residence of Decedent  10a. State 10b. County                                                                            |                                                             | 10c. City, Tow                  | m or Loc           | cation                                                       |                                  |                               |                                               |                             |                                | 0d. Inside City Limits                       |
|            | Maryl<br>f sho                                                                                                                                | 0                | MD Montgo                                                                                                                      | merv                                                        |                                 |                    | ville                                                        |                                  |                               |                                               |                             |                                | ¥ Yes 2 No                                   |
|            | 28a                                                                                                                                           | rec              | 10e. Street and Number                                                                                                         |                                                             |                                 |                    | 10f. Zip Code                                                |                                  |                               | 1                                             | 0g. Citizen                 | of What Cour                   | ntry?                                        |
|            | h with                                                                                                                                        | Funeral Director | 220 Spring Ave                                                                                                                 |                                                             |                                 |                    | 20                                                           | 0850                             |                               |                                               | U                           | .S.A.                          |                                              |
|            | items 2                                                                                                                                       | ner              | 11. Marital Status                                                                                                             | 12. Was Deceden<br>Armed Forces                             | Ever in U.S.                    | 13. V              | Vas Decedent of H<br>Yes, specify Cuba                       | lispanic O                       | rigin? (Spec                  | rfy Yes or No-                                |                             | Race - Americ<br>Black, White, |                                              |
| 36         | within 72 hours after death with the Maryland<br>ane<br>than "natural", or items 23a or 28a-f show<br>the Medical Eranii er rust ke rutilisud | y Fu             | Never Married 2 ☐ Married                                                                                                      | 1 ☐ Yes 2 ☐<br>If Yes, Give                                 | No                              | - 1                | ☐ Yes 2 No                                                   | Specify                          |                               | ican, etc.)                                   |                             | ecify:Blac                     |                                              |
| Ö          | hours<br>tural                                                                                                                                | d by             | 3 Widowed 4 Divorced                                                                                                           | Year or Dates:                                              | 1.40-                           |                    |                                                              |                                  |                               |                                               |                             |                                |                                              |
| 21215-0036 | in 72<br>n"n<br>neulic                                                                                                                        | olete            | 15. Decedent's Edu<br>(Specify only highest grad                                                                               | le completed)                                               |                                 | (Give I<br>life. D | ent's Usual Occup<br>kind of work done<br>OO NOT use retired | ation<br><i>duri</i> ng mo<br>d) | st of working                 | 9                                             | 16b. Kind o                 | f Business/Ind                 | dustry                                       |
| 212        | e filed withir<br>al Hygiene.<br>I other than<br>vent, the M                                                                                  | Completed        | Elementary/Secondary (0-12)<br>12th                                                                                            | College (1-4or                                              | 5+) F:                          |                    | sekeepe:                                                     |                                  |                               |                                               | Navy                        | y Med:                         | ical                                         |
| ם          | be filed within 72 ho<br>ital Hygiene.<br>id other than "natur<br>event, the Me Jical                                                         | Bec              | 17. Father's Name (First, Middle, Last)                                                                                        | ** 11                                                       |                                 |                    |                                                              |                                  | . '                           | First, Middle, I                              |                             | na <i>m</i> e)                 |                                              |
| <u>yla</u> | 2 should be f<br>and Mental h<br>is marked of<br>raumatic ever                                                                                | ု                | Melvin H.                                                                                                                      | Hall                                                        |                                 |                    |                                                              |                                  | Louis                         | е ва                                          | rcus                        |                                |                                              |
| Maryland   | es 1 and 2 should to Health and Ment fitem 27 is marked rother traumatic e                                                                    | p 1              | 19a. Informant's Name/Relationship (T)                                                                                         |                                                             | 1                               |                    | Address (Street                                              |                                  |                               |                                               |                             | ·                              |                                              |
|            | 1 and<br>Health<br>em 27<br>ther tr                                                                                                           | - 3              | Melvin A. Hall                                                                                                                 | - Broth                                                     |                                 |                    | Elizabe                                                      |                                  | Ave 1                         |                                               |                             | MD 20                          |                                              |
| Baltimore, |                                                                                                                                               |                  | 1 🖾 Surial 2 ☐ Cremation 3 ☐ F                                                                                                 |                                                             | )   _ (                         | - 1                | ition (Name of<br>atory or other place                       | - 1                              |                               |                                               |                             |                                |                                              |
| ∄          |                                                                                                                                               |                  | *4 □ Donation 5 □ Other (Specify)  21. Signature, f Funeral Service Licentary                                                  |                                                             | Linke                           | $\frac{1}{22}$     | Park Co                                                      | em  <br>ss of Faci               | 2/16/                         | /08                                           | Rocky                       | ville                          | , MD                                         |
| B          | permit. Departr Imports any inju                                                                                                              |                  | Genege                                                                                                                         | A Su                                                        | out !                           |                    |                                                              |                                  |                               |                                               |                             |                                | MD 20850                                     |
|            | - 111                                                                                                                                         |                  | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only o                                                 | ications that cause                                         | d the death.                    | _                  |                                                              |                                  |                               |                                               |                             |                                | Approximate<br>Interval Between              |
|            | Pnysician                                                                                                                                     |                  | Immediate Cause (Final disease or condition                                                                                    | III Cause OII eacil                                         | SEF                             |                    |                                                              |                                  |                               |                                               |                             |                                | Onset and Death                              |
|            | /Medical                                                                                                                                      |                  | resulting in death)                                                                                                            | Due to (or as                                               | a consequence                   |                    |                                                              |                                  |                               |                                               |                             |                                |                                              |
| M          | Examiner                                                                                                                                      | L                | Sequentially list conditions,                                                                                                  | b                                                           |                                 |                    | ronA                                                         |                                  |                               |                                               |                             |                                |                                              |
|            | ed sit                                                                                                                                        | Examiner         | Sequentially list conditions, if any, leading to immediate the first librarying Cause (Disease or injury that initiated events | Due to (or as                                               | a consequence                   | of):               |                                                              |                                  |                               |                                               |                             |                                |                                              |
|            | xecut<br>and<br>al-trar                                                                                                                       | xan              | that initiated events resulting in death) Last                                                                                 | Due to (or as                                               | a consequence                   | of):               |                                                              |                                  |                               |                                               |                             |                                |                                              |
| 8760,      | cate be executed<br>physician and<br>the burial-transit                                                                                       | dlcalE           |                                                                                                                                | 4                                                           |                                 |                    |                                                              |                                  |                               |                                               |                             |                                |                                              |
| 9          |                                                                                                                                               | 0                |                                                                                                                                |                                                             |                                 |                    |                                                              |                                  |                               |                                               |                             |                                |                                              |
| Вох        | death certifi<br>e attending  <br>id for use as                                                                                               | Physician/M      | 230. Was decedent pregnant                                                                                                     | 3c. If yes, outcome                                         | of pregnancy<br>2 🗆 Fetal death | 3 🗆                | Ectopic pregnancy                                            | ,                                |                               |                                               |                             | Date of delive                 | ,                                            |
|            | 0 0                                                                                                                                           | sicie            | in the past 12 months?  1 Yes 2 No                                                                                             |                                                             | t time of death                 |                    | Other (specify)                                              |                                  |                               |                                               |                             | Month                          | Day Year                                     |
| O.         | that the de<br>ed by the a<br>detached t                                                                                                      | Phy              | 9 Unknown                                                                                                                      |                                                             |                                 |                    |                                                              |                                  |                               | an Bideel                                     |                             |                                | 4.1.40                                       |
| Records,   | sign<br>sign<br>d be                                                                                                                          | ed by            | Part II. Other significant conditions co                                                                                       | ntributing to death                                         | out not resulting ii            | n the un           | derlying cause giv                                           | en in Part                       |                               |                                               | os 21/21 No                 |                                | ne cause of death? ably 4 □Unknown           |
| 000        | as b                                                                                                                                          | ompleted         |                                                                                                                                |                                                             |                                 |                    |                                                              |                                  |                               | 24a. Was a                                    |                             | b. Were auto                   | psy findings available inpletion of cause of |
| _          | The<br>ate h<br>page                                                                                                                          | Com              |                                                                                                                                |                                                             |                                 |                    |                                                              |                                  |                               | autops<br>perform                             | ned?                        | death?                         | 4                                            |
| Vital      | sician: Th<br>certificate<br>rector, pag                                                                                                      | Be (             | 25. Was case referred to medical examiner?                                                                                     |                                                             |                                 |                    |                                                              | 26. Plac                         | e of Death (                  | Check only on                                 | θ)                          |                                |                                              |
| ot         | Physician:<br>this certific<br>ral director,                                                                                                  | 2                | 10 185 20 110                                                                                                                  | lospital: 1 ☐ Inpati                                        |                                 |                    |                                                              | 4 75                             |                               | e 5 ☐ Reside                                  |                             |                                | 1)                                           |
|            |                                                                                                                                               | ion              | 27. Manner of Death  1 ☑ Natural 5 ☐ Pending                                                                                   | 28a. Date of Inj<br>(Month, Da                              |                                 | Time of<br>injury  | 28c. Injun<br>Wor                                            | yat<br>k?<br>Yes 2.⊑             |                               | ld. Describe ho                               | w injury oc                 | curred                         |                                              |
| Division   | ten<br>leat<br>tor:<br>the                                                                                                                    | licat            | 2 Accident investigation 3 Suicide 6 Could not be determined                                                                   | 28e. Place of In                                            | jury - At home, fa              | ırm stre           |                                                              | 105 2                            |                               | If Location /St                               | reet and Nu                 | imber or Rura                  | I Route Number.                              |
| 2          | al or A<br>s after<br>i Dire<br>d in b                                                                                                        | Certification:   | 4  Homicide determined                                                                                                         | building, e                                                 | tc. (Specify)                   | , 00               | ot, lastory, office                                          |                                  |                               | City or Towr                                  |                             |                                | , riodio ratinosi,                           |
|            | To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by                                                    | edical C         | 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami                                                               | sician: To the best<br>ner: On the basis of<br>and manner s | of examination an               | e, death           | occurred at the tinestigation, in my o                       | ne, date a<br>pinion, de         | ind place, an<br>ath occurred | d due to the call<br>at the time, da          | ause(s) and<br>ate and plac | manner as st<br>ce, and due to | ated.<br>the cause(s)                        |
|            | within 2.                                                                                                                                     | Me               | 29b. Signature and title of certifier                                                                                          |                                                             |                                 |                    | 29c. License                                                 | e number                         |                               | 2                                             | 9d. Date sig                | ned (Month,                    | Day, Year)                                   |
|            | 5                                                                                                                                             |                  | > Zmm/                                                                                                                         | sers!                                                       | M(0)                            |                    | 00                                                           | 05                               | 7/2                           | 4                                             | 21                          | 1110                           | 8                                            |
|            |                                                                                                                                               |                  | 30. Name and address of person who co                                                                                          | empleted cause of                                           | death (Item 23a)                | (Туре, Р           | Print)                                                       |                                  |                               |                                               |                             |                                |                                              |
|            |                                                                                                                                               |                  | Truong Bao, MD                                                                                                                 | 9715 M                                                      | edical                          | Cer                | nter Dr                                                      | #210                             | Roc                           | kville                                        | , MD                        | 2085                           | 0                                            |
|            | Sta                                                                                                                                           |                  | 31. Date filed (Month, Day, Year)                                                                                              | 32 Regist                                                   | rar's Signature                 | Ana                | A 3                                                          |                                  |                               |                                               |                             |                                |                                              |
|            | Registr                                                                                                                                       | वा               | FEB 1 4 200                                                                                                                    | O RESTRA                                                    | 1 10 1                          | 1                  | - Bran                                                       |                                  |                               |                                               |                             |                                |                                              |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Edward Paul HULTSCH 18, 11:35 a.<sup>M</sup> February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 411 N. Colonial Drive Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 3, 19 5. Social Security Number . Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1 X M 2 □ F 1944 214-42-0827 63 Maryland Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 1 XYes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 411 N. Colonial Drive 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Allied Foces: 1 Styles 2 □ No If Yes, Give Year or Dates: 1967–69 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ◯XNo Specify Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 fabricator 0 metal works 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P Robert E. Hultsch Pauline F. Brandenburg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Susan M. Hultsch - wife 411 N. Colonial Dr., Hagerstown, Maryland 21740 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
important: If iter
any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Cedar Lawn Mem.Park 2/22/08 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 mile Approximate Interval Between Onset and Death 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 2v Immediate Cause (Final Physician Week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated exerts.) Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has bage 2 s autopsy performed death? 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: Medical Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation death. ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled + Certifying Physician: To the lest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check or one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the and title of certifier 29c. License number 29b. Signature

State Registrar 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

11110

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Betty Colleen HARRISON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1150 Rose Hill Avenue Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2 👿 F Months Days Hours Director 79 218-24-7747 1 1928 Pennsylvania Nov. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notifled at 1 X Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1150 Rose Hill Avenue 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or iter any Injury or other traumatic event, the Medical Examines one. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver Francis Bowling Perle Lorraine Spence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Foreman - Daughter 1150 Rose Hill Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/20/08 Rose Hill Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner SHOCK Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p

ed by the a s been signed by the should be detached þ Completed cate has by page 2 s Be Medical Certification: To After this funeral ours after death. neral Director: A filled in by the fu Within 24 hours a

| Sequentially list conditions, it any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | cDue to (or as a consect of                                                                         | . ,                                                  |                                                       |                                                        |                                                                  |                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------|--------------------|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 □ No 9 □ Unknown                                                                   | 23c. If yes, outcome pf pregn<br>1 ☐ Live birth 2 ☐ Fet<br>4 ☐ Pregnant at time of o<br>9 ☐ Unknown | al death 3 □ Ectopic p                               |                                                       |                                                        | 23d. Date of delivery<br>Month Day Ye                            | ear                |
| Part II. Other significant condition                                                                                                                       |                                                                                                     |                                                      | cause given in Part I                                 | 23e. Did tobacc                                        | o use contribute to the cause of dec                             |                    |
| ///                                                                                                                                                        |                                                                                                     |                                                      |                                                       | 24a. Was an autopsy performed 1 Yes 2 2 2 2            |                                                                  | /ailable<br>use of |
| 25. Was case referred to medical                                                                                                                           |                                                                                                     |                                                      | 26. Place of De                                       | eath (Check only one)                                  |                                                                  |                    |
| examiner?<br>1 ☐ Yes 2 No                                                                                                                                  | Hospital: 1 ☐ Inpatient 2 ☐                                                                         | ]ER/Outpatient 3 □ D                                 | OA Other: 4 Nursing                                   | Home 5 Residence                                       | 6 ☐Other (Specify)                                               |                    |
| 27. Manner of eath  ↑ Natural 5 Pending 2 Accident investiga                                                                                               |                                                                                                     | 28b. Time of Injury                                  | 28c. Injury at<br>Work?<br>1                          | 28d. Describe how in                                   | jury occurred                                                    |                    |
| 3 ☐ Suicide 6 ☐ Could no determin                                                                                                                          |                                                                                                     | ome, farm, street, factor                            | y, office                                             | 28f. Location (Street<br>City or Town, Sta             | and Number or Rural Route Numb<br>ate)                           | er,                |
| 29a. Certifier (Check only one)  Gheck only Medical E                                                                                                      | Physician: To the best of my know<br>xaminer: On the basis of examinand manner stated.              | owledge, death occurred<br>ation and/or investigatio | d at the time, date and plan, in my opinion, death oc | ce, and due to the cause<br>curred at the time, date a | e(s) and manner as stated.<br>and place, and due to the cause(s) |                    |
| 20h Cieneture and title of cortifier                                                                                                                       |                                                                                                     | 200                                                  | a Licanca number                                      | 1 004 1                                                | Data signal (March Day Vord)                                     |                    |

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

(Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                         |                                                                                                                                                                      |                | 1- For State of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Depa | artment of Health and M<br>rtificate of Death                                            | , ,                                    | 0000 00110                                                           |
|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------|
| M.                                      |                                                                                                                                                                      | 111            | Registrar  1. Decedent's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | lilicate of Death                                                                        | Reg.<br>2. Date of Death               | No. 7 1 3. Time of Death                                             |
| ľ                                       | Physici                                                                                                                                                              |                | Edwin Earl Hindman                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                          | Month                                  | 9, 2008 9:40 AM                                                      |
|                                         | /Medio<br>Examin                                                                                                                                                     |                | 4a. Facility Name (If not institution, give street and number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4b. City, Town, or Location of Death                                                     |                                        | 4c. County of Death                                                  |
| J                                       |                                                                                                                                                                      |                | Crofton Convalescent Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Crofton                                                                                  | A                                      | anne Arundel                                                         |
|                                         | Funeral                                                                                                                                                              |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.                        | 8. Date of Birth<br>(Month, Day, Ye    | 9. Birthplace (State or Foreign Country)                             |
| 0                                       | Director                                                                                                                                                             |                | 577-20-1856 1X M 2 F 88 Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Months Days Hours With.                                                                  | Aug. 27,                               | 1919 Kentucky                                                        |
|                                         | and<br>w                                                                                                                                                             |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | cation                                                                                   |                                        | 10d. Inside City Limits                                              |
|                                         | Maryl<br>f sho                                                                                                                                                       | JO.            | Maryland Worcester Berlin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                          |                                        | 1 □Yes 2XNo                                                          |
|                                         | the 28a                                                                                                                                                              | Director       | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 10f. Zip Code                                                                            | 10g.                                   | Citizen of What Country?                                             |
|                                         | h with                                                                                                                                                               | al D           | 228 Charleston Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 21811                                                                                    | US                                     |                                                                      |
|                                         | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ither than "natural", or items 23a or 28a-f show<br>ont, the Medical Examiner must be notified at | Funeral        | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Was Decedent of Hispanic Origin? (Spe<br>If Yes, specify Cuban, Mexican, Puerto          |                                        | 14. Race - American Indian,                                          |
| 9                                       | or it                                                                                                                                                                | / Fu           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 ☐ Yes 2 No Specify:                                                                    | rican, etc.,                           | Black, White, etc.  Specify:                                         |
| 21215-0036                              | hours<br>ural";                                                                                                                                                      | d by           | 3 N vvidowed 4 Divorced Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          |                                        | White                                                                |
| <del>7</del>                            | in 72<br>i "nat<br>ledic                                                                                                                                             | Completed      | (Specify only highest grade completed) (Give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | dent's Usual Occupation<br>kind of work done during most of worki<br>DO NOT use retired) | na                                     | Kind of Business/Industry neral Accounting                           |
| 72                                      | with<br>iene.<br>thar                                                                                                                                                | omp            | Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ,                                                                                        |                                        | ice                                                                  |
| פַ                                      | other<br>vent, tt                                                                                                                                                    | Be C           | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          | (First, Middle, Maid                   |                                                                      |
| <u>a</u>                                | should be and Mental smarked o                                                                                                                                       | To B           | Leroy Hindman                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Rose Ann                                                                                 | Marie Cam                              | npbell                                                               |
| Maryland                                | 2 sho<br>and l<br>is ma                                                                                                                                              |                | A1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ng Address (Street and Number or Rura                                                    | al Route Number, Cit                   | ty or Town, State, Zip Code)                                         |
|                                         | 1 and 2<br>Health<br>tem 27 i                                                                                                                                        |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Charleston Road Be                                                                       |                                        |                                                                      |
| ltimore,                                | 0 4 = 0                                                                                                                                                              |                | 20a. Method of Disposition  1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Densition 5 ☐ Other (Specific)  FOR Li                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | natory or other place)                                                                   | Date 20c.                              | Location - City or Town, State                                       |
| Ħ                                       | it. Partmer<br>rtant:<br>njury                                                                                                                                       |                | Cemete                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | rv : 2/13/                                                                               | /2008 Bre                              | entwood, MD                                                          |
| Ba                                      | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.                                                                                             |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Name and Address of FacilityRobe                                                         |                                        |                                                                      |
|                                         |                                                                                                                                                                      |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one caus, on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6000 Annapolis Roa                                                                       |                                        | MD ZU/15 Approximate                                                 |
| .=                                      | Physician                                                                                                                                                            |                | Immediate Cause (Final                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          |                                        | Interval Between<br>Onset and Death                                  |
| 1                                       | /Medical                                                                                                                                                             |                | disease or condition resulting in death)  a. /// up to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | eamonia                                                                                  |                                        |                                                                      |
|                                         | Examiner                                                                                                                                                             |                | Por located will                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ~ Chrise                                                                                 |                                        |                                                                      |
|                                         | p #                                                                                                                                                                  | ner            | if any, leading to immediate ue to or s a consequence of).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                          |                                        |                                                                      |
|                                         | ecute<br>and<br>-trans                                                                                                                                               | Examiner       | Cause (Disease or injury that initiated events c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                          |                                        |                                                                      |
| 8760,                                   | cate be executed<br>physician and<br>the burial-transit                                                                                                              |                | Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                          |                                        |                                                                      |
| 287                                     | 요 는 는                                                                                                                                                                | dical          | d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                          |                                        |                                                                      |
| Box                                     | death certifi<br>e attending I<br>d for use as                                                                                                                       | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          |                                        | 23d. Date of delivery                                                |
| ň                                       | death<br>d for                                                                                                                                                       | icial          | in the past 12 months?  1 Ves 2 No.  1 Pregnant at time of death 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Ectopic pregnancy Other (specify)                                                        |                                        | Month Day Year                                                       |
| J.                                      | t the<br>by the<br>tache                                                                                                                                             | hys            | 9 ☐ Unknown 9 ☐ Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          |                                        |                                                                      |
|                                         | The law requires that the de<br>te has been signed by the a<br>lage 2 should be detached to                                                                          | by P           | Part II. Other significant conditions contributing to death but not resulting in the ur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | nderlying cause given in Part I.                                                         | 23e. Did tobacc                        | to use contribute to the cause of death?                             |
| or c                                    | w requir<br>been si<br>should                                                                                                                                        |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          | 1 ☐ Yes                                | 2☑No 3☐ Probably 4☐Unknown                                           |
| Vital Records,                          | law<br>las b                                                                                                                                                         | Completed      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          | 24a. Was an autopsy                    | 24b. Were autopsy findings available prior to completion of cause of |
| <u></u>                                 | (0 (2                                                                                                                                                                | S              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          | performed                              | death?                                                               |
| ======================================= | Physician: The law trinis certificate has trail director, page 2 s                                                                                                   | Be             | 25. Was case referred to medical examiner?  Hospital: Hospital:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 26. Place of Death                                                                       |                                        |                                                                      |
| ō                                       | this ald                                                                                                                                                             | 2              | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien  27. Manney of Death 28a. Date of Injury 28b. Time of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1 3 DOA 4 Nursing Hor                                                                    | ne 5 Residence<br>28d. Describe how in | 6 Other (Specify)                                                    |
| on                                      | nding P<br>th.<br>: After t<br>e funera                                                                                                                              | tion           | 1 12 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No                                                   | Lod. Describe flow ii                  | ijury occurred                                                       |
| UIVISION                                | or Attending<br>after death.<br>Director: Afte<br>in by the fune                                                                                                     | ifica          | 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, str.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | eet, factory, office                                                                     | 28f. Location (Street                  | and Number or Rural Route Number,                                    |
| בֿ                                      | tal or A<br>s after<br>al Dire<br>ed in b                                                                                                                            | Certification: | 4 ☐ Homicide building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                          | City or Town, St                       | ate)                                                                 |
|                                         | iospii<br>t hour<br>uner                                                                                                                                             |                | 29a. Certifier (Check only (Check only 2   Medical Examiner: On the basis of examination and/or in-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | o occurred at the time, date and place, a                                                | and due to the cause                   | e(s) and manner as stated.                                           |
|                                         | To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by                                                                          | Medical        | and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                          |                                        |                                                                      |
|                                         | N N N                                                                                                                                                                |                | 29b. Signature and title of deptitie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 29c. License number                                                                      |                                        | Date signed (Month, Day, Year)                                       |
|                                         |                                                                                                                                                                      | -              | 20 Name and The section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the secti | 238428                                                                                   | 2                                      | 111/08                                                               |
|                                         | 20                                                                                                                                                                   |                | 30. Name and address of person who completed cause of death (Item 23a) (Type,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                          | 1 60. 1                                | Purne MD21061                                                        |
|                                         | Sta                                                                                                                                                                  | te             | 31. Date filed (More EB Mar) 2008 32 Legistrar's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1 19 way 3 0                                                                             | ven!                                   | DUXING MIDALUU                                                       |
|                                         | Registra                                                                                                                                                             |                | LU - LOUD MARINE ST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | OSALIV /                                                                                 |                                        |                                                                      |

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|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------|-----------------------------|------------------------------------|--------------------------------|---------------------------------|--------------------------|-------------------------------|--------------------------------------------------|
|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | Registrar  1. Decedent's Name (First, Middle, Last)                                                                              |                                                  |                                           | incate                      | or Dea                             |                                | 2. Date of De                   | Reg. No.                 |                               | 3. Time of Death                                 |
| Н                   | Physici                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | an             | Lora Eileen Hamm                                                                                                                 | - n d                                            |                                           |                             |                                    |                                | Month                           | Day                      |                               |                                                  |
|                     | /Medic<br>Examin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | 4a. Facility Name (If not institution, give s                                                                                    |                                                  |                                           | 4b. City. T                 | own, or Locat                      | tion of Death                  | Februa                          |                          | 6, 2008<br>County of Dea      |                                                  |
|                     | Exami                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | er             | Williamsport Nursi                                                                                                               |                                                  |                                           |                             | iamspo                             |                                |                                 |                          | shingto                       |                                                  |
|                     | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | Social Security Number                                                                                                           |                                                  | yrs. last birthday)                       | If Under 1                  | Year If Un                         | nder 24 Hrs.                   | 8. Date of Bir                  | th                       |                               | thplace (State or Foreign ountry)                |
|                     | Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | 217-18-8842                                                                                                                      | M 21XF                                           | 82 Yrs.                                   | Months                      | Days Hou                           | urs Min.                       | (Month, Da<br>Feb.27            |                          |                               | ountry)<br>Tyland                                |
|                     | p.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | Usual Residence of Decedent                                                                                                      |                                                  |                                           |                             |                                    |                                |                                 | 1,,,,                    |                               |                                                  |
|                     | aryla<br>ehov                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | _              | 10a. State 10b. County                                                                                                           | 10                                               | c. City, Town or La                       | cation                      |                                    |                                |                                 |                          |                               | 10d. Inside City Limits  12€ Yes 2 □ No          |
|                     | 88-1 W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Director       | Maryland Washingto                                                                                                               | n 1                                              | Maugansvi                                 |                             |                                    |                                |                                 |                          |                               |                                                  |
|                     | Mith E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | D I            | 10e. Street and Number                                                                                                           |                                                  |                                           | 10f. Zip (                  |                                    |                                |                                 | =                        | zen of What C                 | ountry?                                          |
|                     | • 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Funeral        | 14011 Village Mill                                                                                                               |                                                  | :- 11.0                                   | 2176                        |                                    | 0:-:-0:0                       |                                 | USA                      | 14 0000 4-                    | -day to di-                                      |
|                     | b Fer de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ī              | 11. Marital Status  1 ☐ Never Married 2 ☐ Married                                                                                | 2. Was Decedent Ever<br>Armed Forces?            | r in U.S. 13.                             | Vas Decede<br>f Yes, specif | fy Cuban, Me                       | c Origin? (Sp<br>xican, Puerto | ecify Yes or No<br>Rican, etc.) | ).                       | 14. Race - Am<br>Black, Whi   |                                                  |
| 99                  | irs af                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | by             | 3 ☐ Widowed 4 ☑ Divorced                                                                                                         | 1 ☐ Yes 2 ☒ No<br>If Yes, Give<br>Year or Dates: |                                           | 1 ☐ Yes 2                   | No Spe                             | city:                          |                                 |                          | Specify: W                    | hite                                             |
| ğ                   | be filed within 72 hours after death with the Maryland Hyglone.  d other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be inclified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ed             | 15. Decedent's Educ                                                                                                              | ation                                            | 16a. Deced                                | ient's Usual                | Occupation                         |                                |                                 | 16b. Kir                 | nd of Business                |                                                  |
| 7                   | Name of the Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Parish Pari | Completed      | (Specify only highest grade<br>Elementary/Secondary (0-12)                                                                       | Completed) College (1-4or 5+)                    | (Give                                     | kind of work<br>DO NOT use  | Occupation done during of retired) | most of work                   | ing                             |                          |                               | ,                                                |
| 2                   | d will                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | E              | 12                                                                                                                               | O (1-401 3+)                                     | Cler                                      | k                           |                                    |                                |                                 | Ele                      | ctronic                       | s Manufac.                                       |
| ٦                   | e filed<br>ai Hygle<br>other<br>vent, it                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Bec            | 17. Father's Name (First, Middle, Last)                                                                                          |                                                  |                                           |                             | 18. M                              | other's Nam                    | e (First, Middle,               |                          |                               |                                                  |
| <u>ā</u>            | should be<br>nd Mental<br>marked c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ToE            | Harry Raymond Da                                                                                                                 | vis                                              |                                           |                             | Mar                                | rv Ka                          | te Mil                          | ler                      |                               |                                                  |
| Maryland 21215-0036 | s 1 and 2 should<br>f Health and Mer<br>item 27 is marke<br>other traumatic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                | 19a. Informant's Name/Relationship (Typ                                                                                          | oe, Print)                                       | 19b. Mailir                               | g Address (                 |                                    |                                | al Route Numb                   |                          | Town, State,                  | Zip Code)                                        |
| Σ.                  | 1 and 1<br>Health<br>tem 27<br>other tru                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | Hal Hammond (Son                                                                                                                 | )                                                | 11320                                     | Marbe                       | ern Roa                            | ad Hag                         | erstown                         | , Mai                    | ry land                       | 21740                                            |
| 9                   | es 1 ar<br>of Hea<br>fitem<br>r other                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | 20a. Method of Disposition                                                                                                       | 1                                                | Ob. Place of Dispo                        | sition (Name                | e of                               |                                | Date                            |                          | cation - City or              | Town, State                                      |
| Ĕ                   | Pages<br>nent of I<br>ant: If it                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)                                                              |                                                  | Smithsbur                                 | o Cre                       | matory                             | Feb                            | 18 2008                         | Smi                      | thehur                        | g, Maryland                                      |
| Baltimore,          | permit. Pages<br>Department of<br>Importent: If it<br>eny injury or o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | 21. Signatura of Fune Al Service License                                                                                         | 0                                                | 22                                        | Name and                    | Address of F                       | acility                        | D A                             | 425                      | Cauth                         | Conococheagu                                     |
| <b>m</b>            | 82 5 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                | Dettech                                                                                                                          |                                                  | St                                        | reet v                      | Villian                            | nsport                         | , Maryl                         | and 2                    | 30uTn<br>21795                | Conococneagu                                     |
|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on                                                 | cations that caused the                          |                                           |                             |                                    |                                |                                 |                          |                               | Approximate<br>Interval Between                  |
| F                   | hysician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | fmmediate Cause (Final disease or condition                                                                                      | PNEUmo                                           |                                           |                             |                                    |                                |                                 |                          |                               | Onset and Death                                  |
|                     | /Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | resulting in death)                                                                                                              | Due to (or as a co                               |                                           |                             |                                    |                                |                                 |                          |                               | 2 DITTY                                          |
|                     | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | Out and the first are first and the                                                                                              |                                                  |                                           |                             |                                    |                                |                                 |                          |                               |                                                  |
|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ner            | Sequentially list conditions, fraint leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a co                               | nsequence of):                            |                             |                                    |                                |                                 |                          |                               |                                                  |
|                     | cutec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Examiner       | Cause (Disease or injury that initiated events                                                                                   |                                                  |                                           |                             |                                    |                                |                                 |                          |                               |                                                  |
| 760,                | be executed icien and burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Ä              | resulting in death) Last                                                                                                         | Due to (or as a co                               | nsequence of):                            |                             |                                    | ·                              |                                 |                          |                               |                                                  |
|                     | 9 %                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Icai           | d                                                                                                                                |                                                  |                                           |                             |                                    |                                |                                 |                          |                               |                                                  |
| 89                  | death certificat<br>e ettending phy<br>id for use as th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Physician/Med  | IF FEMALE:                                                                                                                       |                                                  |                                           |                             |                                    |                                |                                 | -                        |                               |                                                  |
| Вох                 | iff ce<br>tendi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | an/            | 23b. Was decedent pregnant 23                                                                                                    | 3c. If yes, outcome of pour 1 ☐ Live birth 2 ☐   |                                           | Ectopic pre                 | onancy                             |                                |                                 | 2                        | 3d. Date of de                | •                                                |
|                     | 0 60                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | sici           | in the past 12 months?                                                                                                           | 4☐ Pregnant at time<br>9☐ Unknown                |                                           | Other (spec                 |                                    |                                |                                 |                          | Month                         | Day Year                                         |
| o.                  | that the de<br>ed by the<br>detached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Ph             | 9 □Unknowń                                                                                                                       |                                                  |                                           |                             |                                    |                                |                                 |                          |                               |                                                  |
| Ś.                  | 8 5 B                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | by             | Part II. Other significant conditions con                                                                                        |                                                  |                                           | nderlying cau               | use given in P                     | art I.                         | 0.00                            | _                        | _                             | o the cause of death?                            |
| 0.0                 | w requir<br>been si<br>should                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ted            | ADVANCED SENI                                                                                                                    |                                                  | NENTIA                                    |                             |                                    |                                | 183                             | Yes 2                    | _No_3∐P                       | robably 4 Unknown                                |
| ပ္                  | 198 b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | pje            | ENDSTAGE CHEONIC                                                                                                                 | . CIBSTRUCTI                                     | VE PHILM                                  | CHARY                       | DISCA                              | KE_                            | 24a. Was                        | DSV                      | 24b. Were a                   | utopsy findings available completion of cause of |
|                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Completed      |                                                                                                                                  |                                                  |                                           |                             |                                    |                                | perfo                           | rmed?<br>2 A No          | death?                        | s 2□No                                           |
| <b>≣</b> .          | certificate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Be             | 25. Was case referred to medical examiner?                                                                                       |                                                  | -2752                                     |                             | 26. P                              | lace of Deat                   | Check only o                    |                          |                               |                                                  |
| 5                   | Physic<br>this c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ၉              | 10 105 20 110                                                                                                                    | ospital: 1 Inpatient                             | 2 ER/Outpatien                            | t 3□ DOA                    | Other: 4.8                         | Nursing Ho                     | me 5 🗆 Resid                    | dence 6                  | Other (Spe                    | ecify)                                           |
| ב<br>ב              | After 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ë              | 27. Manner of Death 1    Natural 5 □ Pending                                                                                     | 28a. Date of Injury<br>(Month, Day Ye.           | ar) 28b. Time of<br>Injury                | 28                          | c. Injury at<br>Work?              |                                | 28d. Describe I                 | how injury               | occurred                      |                                                  |
| <u> </u>            | death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | cati           | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be                                                                          |                                                  |                                           | М                           | 1 Tes 2                            | 2 □No                          | <u></u>                         |                          |                               |                                                  |
| Division            | or Atten<br>after deat<br>Director:<br>in by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Certification: | 4 Homicide determined                                                                                                            | 28e. Place of Injury -<br>building, etc. (S      | At home, farm, stre<br>pecify)            | eet, factory,               | office                             |                                | 28f. Location (S<br>City or Tox | Street and<br>wn, State) | d Number or R                 | ural Route Number,                               |
| _                   | urs a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                |                                                                                                                                  |                                                  |                                           |                             |                                    |                                |                                 |                          |                               |                                                  |
|                     | To the nespital of Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Medical        | (Check only 2   Medical Examin                                                                                                   | er: On the basis of exa                          | y knowledge, death<br>mination and/or inv | estigation, in              | t the time, date<br>n my opinion,  | e and place,<br>death occurr   | and due to the ed at the time,  | date and                 | and manner a<br>place, and du | s stated.<br>e to the cause(s)                   |
| ,                   | the the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Wed            | one) 29b. Signature and title of certifier                                                                                       | and manner stated.                               | · · · · · · · · · · · · · · · · · · ·     |                             | License numb                       |                                |                                 |                          |                               |                                                  |
| 1                   | 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | -              | 1ethouse and this of certifier                                                                                                   | . ^                                              |                                           |                             |                                    |                                |                                 | عصر. Dati                | a signed (Mon                 |                                                  |
| 0                   | 1/2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                | JOHOUR IN                                                                                                                        | M                                                |                                           |                             | 3370                               |                                |                                 | tebn                     | wary 1                        | 1,2008                                           |
|                     | '\                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | }              | 30. Name and address of person who cor                                                                                           | 24 A L A                                         | A                                         |                             |                                    | mn-                            | 121                             | **                       | 21795                         |                                                  |
| A.                  | Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | to.            | JED E. HOWE 15 31. Date filed (Month, Day, Year)                                                                                 | 32. Resistrar's                                  | Signature                                 | 197                         | LIAMS                              | TOKI,                          | MD                              |                          | 41173                         | )                                                |
|                     | Registr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                |                                                                                                                                  | 08                                               | M A                                       | book                        | P                                  |                                |                                 |                          |                               |                                                  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First\_Middle\_Last) 2. Date of Death Month **Physician** Renee' February 6, Sherry 2008 22:28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Hospital Cheverly
If Under 1 Year | If Under 24 Hrs. Prince George's 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 □ F Director 212-11-9862 Usual Residence of Decedent 36 Feb 9, 1971 Washington, DC filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1tgTYes 2∐No Directo Maryland | Prince George's Capitol Heights 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or idical Examiner must be r 1404 Farmingdale Avenue 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Cashier Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 ment of Health and Mental i ant: If item 27 is marked o Edward R. Johnson 7 is marked traumatic Elaine T. Gist 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine T. Johnson - Mother 1404 Farmingdale Ave. Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Onation 5 ☐ Other (Specify) = 5 permit. Page Department of Important: if any injury or once, Ft. Lincoln Cemt. Feb 18, 2008 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Duer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, an eart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia **Physician** /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, Due to for as a nonsequence off-Examiner ll any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Human Immunodeficiency Virus Advanced Disease physician and s the burlal-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical Pulmonary Tuberculosis as 1 IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) signed by the 9 AUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes \$ ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has irector, page 2 performed? or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient Certification: To 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 | Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

the

State

Dr. Fisehatswti Mehari 3001 Hospital Drive Cheverly, MD 20785 31. Date filed (Month, Day 2008) FEB 1 9 2008 32. Register's Signature

of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

D0064478

29d. Date signed (Month, Day, Year)

February 9, 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 15, 2008 Lawrence Edward /Medical Jones 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital Prince George s

9. Birthplace (State of Country) Lanham 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F Director 175-28-6666 80 Jan 31, 1928 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f shov notified at 1 Yes 2 □ No Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 13301 New Acadia Lane 20774 death v United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Jones,  $L\alpha\omega/\ell n\alpha$ Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 🙀 No Specify: þ 3 Widowed 4 Divorced Year or Dates: American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Security Private if Health and Mental Hygi item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Jones Eleanor White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhina Sewell-Jones / Wife 13301 New Acadia Lane Upper Marlboro, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Vet's Cemt. Feb. 29, 2008 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sign ture of Funeral Cervic License 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final athero sclerotic disease Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 1√No 24a. Was an autopsy performed' nype-PUSION 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

CL (3)

State Registrar 31. Date filed (Month, Day, Year) FEB 1 9 2008

Tucen-Anh

VU, MD 8118 Goodhuck Rd., Lanham, MD. 20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MDD 55697

02/15/08

| _        | -                                                                                                                                                                            |                | 1 - For State Of IVIS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | aryiand / L                              |                        | irtment of H<br><i>tificate of l</i>                    |                                         | and Men                         | _                               |                                  | 08                     | 06447                                         |
|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------|---------------------------------------------------------|-----------------------------------------|---------------------------------|---------------------------------|----------------------------------|------------------------|-----------------------------------------------|
| Е        | Discortain.                                                                                                                                                                  |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | > XI                                     |                        |                                                         |                                         |                                 | Date of Death                   | eg. No.                          | V                      | 3. Time of Death                              |
|          | Physicia<br>/Medic                                                                                                                                                           |                | FRANKIN LEE KIL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ETZEI                                    |                        |                                                         |                                         | FL                              | Youth<br>JUNG                   | 26 20                            | )0J                    | 06:30 AM                                      |
|          | Examin                                                                                                                                                                       | er             | 4a. Facility Name (If not institution, give street and number)  21231 Oswald Lane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                          |                        | 4b. City, Town, or                                      | Location of                             |                                 | ,                               | 4c. County of                    |                        | ngton                                         |
| 34       | Funeral                                                                                                                                                                      |                | 5. Social Security Number 6. Sex 7. Ag                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | e (In yrs. last bir                      | rthday)                | If Under 1 Year                                         | If Under 2                              | 24 Hrs.   8. I                  | Date of Birth                   | 1                                |                        | place (State or Foreign                       |
|          | Director                                                                                                                                                                     |                | 233-02-5473 <sup>1</sup> X <sup>M</sup> 2□ F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 49                                       | Yrs.                   | Months Days                                             | Hours                                   |                                 | (Month, Day,<br>ay 20 ,         |                                  |                        | aryland                                       |
|          | and<br>w                                                                                                                                                                     |                | Usual Residence of Decedent  10a. State 10b. County                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 10c. City, Tow                           | n or Loc               | cation                                                  |                                         |                                 |                                 |                                  | 1                      | Od. Inside City Limits                        |
|          | Maryl<br>-f sho<br>fled a                                                                                                                                                    | tor            | <br>  Maryland   Washington                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                          |                        | Smithsb                                                 | urg                                     |                                 |                                 |                                  |                        | 1 ☐ Yes 2 No                                  |
|          | th the<br>or 28s<br>e noti                                                                                                                                                   | Director       | 10e. Street and Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                          |                        | 10f. Zip Code                                           |                                         |                                 | 10                              | g. Citizen of W                  | /hat Cour              | ntry?                                         |
|          | ath wi                                                                                                                                                                       |                | 21231 Oswald Lane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                          |                        | 2178                                                    |                                         |                                 |                                 |                                  | S.A.                   |                                               |
| 0000     | be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral     | 11. Marital Status  1 □ Never Married 2√ Married  1 □ Never Married 2√ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2 1√ If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                          |                        | Vas Decedent of H<br>f Yes, specify Cuba<br>☐ Yes 2🌠 No | ispanic Orig<br>an, Mexican<br>Specify: | gin? (Specify<br>i, Puerto Rica | Yes or No-<br>an, etc.)         |                                  | k, White,              | can Indian,<br>etc.<br>nite                   |
| ž        | 72 hou<br>natura<br>ical E                                                                                                                                                   | ted            | 15. Decedent's Education<br>(Specify only highest grade completed)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 16a                                      | . Deced                | ent's Usual Occup                                       | ation                                   | t of working                    | 1                               | l<br>16b. Kind of Bu             |                        |                                               |
| 7        | rithin 7<br>ne.<br>nan "r<br>e Med                                                                                                                                           | Completed      | Elementary/Secondary (0-12) College (1-4or s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | i+)                                      | life. E                | kind of work done o                                     | during most<br>f)                       | t ot working                    |                                 | Des de                           |                        |                                               |
| V        | filed w<br>Hygiel<br>Sther th                                                                                                                                                |                | 12 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                          |                        | Guard                                                   | 18. Mother                              | r's Name (Fi                    | rst Middle N                    | Pris                             |                        |                                               |
|          | ould be<br>Mental<br>larked o                                                                                                                                                | To Be          | Charles Franklin Kretzer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                          |                        |                                                         |                                         | · ·                             | Jane S                          |                                  | -,                     |                                               |
| ary      | id A N                                                                                                                                                                       | _              | 19a. Informant's Name/Relationship (Type. Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 19b                                      | b. Mailin              | g Address (Street                                       | and Numbe                               | er or Rural Ro                  | oute Number,                    | City or Town,                    | State, Zip             | Code)                                         |
| , Z      | rt 27                                                                                                                                                                        |                | Michelle M. Kretzer (Wife                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                          |                        | Oswald 1                                                |                                         |                                 |                                 |                                  |                        |                                               |
| 2        | e = 5                                                                                                                                                                        |                | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1                                        |                        | sition (Name of<br>natory or other place                | , -                                     | Februa.                         | ry 💈                            | 20c. Location -                  | •                      |                                               |
|          | permit. Pages<br>Department of<br>Important: If I<br>any injury or once.                                                                                                     |                | 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Smiths                                   |                        | g Cremato  Name and Addres                              |                                         | 28 - 20                         |                                 | Smithsb<br>s Funer               |                        | , Maryland                                    |
| ŏ        | permit. Departr Importa any inj                                                                                                                                              | ~              | Jelice Lac Davis M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 01414                                    | 1                      | 2525 Brad                                               | dbury                                   |                                 |                                 |                                  |                        | land 21783                                    |
|          | 7                                                                                                                                                                            |                | 23a. Fart . Enter the disease, or complications that caused shock, or heart failure. List only one cause of each li                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | I the death. Do                          | not ente               | er the mode of dyin                                     | g, such as                              | cardiac or re                   | piratory arre                   | est,                             |                        | Approximate<br>Interval Between               |
|          | Physician<br>/Medical                                                                                                                                                        |                | Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Ter                                      | 140                    | XXAL                                                    | KU:                                     | Joll                            | Well                            |                                  | 5                      | Interval Between<br>Onse and Death            |
|          | Examiner                                                                                                                                                                     |                | Due to (or as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | a consequence                            | or:                    |                                                         |                                         |                                 |                                 |                                  |                        |                                               |
| à        |                                                                                                                                                                              | ner            | Securifically list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | a consequence                            | of):                   |                                                         |                                         |                                 |                                 |                                  |                        |                                               |
|          | ecuter<br>and<br>transi                                                                                                                                                      | Examiner       | that initiated events .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                          | . 0                    |                                                         |                                         |                                 |                                 |                                  |                        |                                               |
| 00/00    | be ex                                                                                                                                                                        | a<br>E         | Due to (or as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | a consequence                            | or):                   |                                                         |                                         |                                 |                                 |                                  |                        |                                               |
| 00       | tificate be executed<br>g physician and<br>as the burial-transit                                                                                                             | ledical        | d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                          |                        |                                                         |                                         |                                 |                                 |                                  |                        |                                               |
| J. DOX   | attendin<br>for use                                                                                                                                                          | Physician/M    | 1 Yes 2 No 4 Pregnant a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2 Fetal death                            |                        | Ectopic pregnancy Other (specify)                       | ′                                       |                                 |                                 | 23d. Date<br>Mor                 |                        | ery<br>Day Year                               |
| ב        | hat the                                                                                                                                                                      |                | 9 ☐ Unknown  Part II. Other significant conditions contributing to death b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ut not resulting i                       | in the ur              | iderlying cause give                                    | en in Part I                            |                                 | 23e Did toh                     | acco use contr                   | ibute to t             | he cause of death?                            |
| cords,   | sician: The law requires that the di<br>certificate has been signed by the<br>rector, page 2 should be detached                                                              | ed by          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |                        |                                                         |                                         |                                 | 1 □ Ye                          | <b>)</b> -                       |                        | bably 4 □Unknown                              |
| 2        | law re                                                                                                                                                                       | Completed      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |                        |                                                         |                                         | [                               | 24a. Was ar<br>autops           | v l                              | prior to co            | opsy findings available ompletion of cause of |
| 2        |                                                                                                                                                                              |                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |                        |                                                         |                                         |                                 |                                 | No 1                             | death?<br>□Yes         |                                               |
| <b>-</b> | rsiciar<br>s certif<br>lirecto                                                                                                                                               | o Be           | 25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ent 2□ER/Ou                              | utnation               | t 3 DOA Oth                                             | or:                                     |                                 | heck only on                    | e)<br>ence 6 □Othe               | (0                     | ,                                             |
| 5        | ig Phy<br>ter this                                                                                                                                                           | $\vdash$       | 27. Manner of Death 28a. Date of Inju                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ıry 28b.                                 | Time of<br>Injury      | 28c. Injur                                              | 4 🗆 1901                                |                                 | 0                               | w injury occurr                  |                        | <i>TY)</i>                                    |
| 200      | tendlr<br>eath.<br>tor: Af<br>the fur                                                                                                                                        | atio           | Accident investigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | , , , ,                                  | injury                 |                                                         | Yes 2 1                                 | No                              |                                 |                                  |                        |                                               |
|          | tal or At<br>s after d<br>al Direct<br>ed in by                                                                                                                              | Certification: | determined 286. Place of In                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ury - At home, fa<br>c. <i>(Specify)</i> | arm, stre              | eet, factory, office                                    |                                         | 28f.                            | Location (Sta<br>City or Town   |                                  | er or Rura             | al Route Number,                              |
|          | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,             | Medical (      | 29a. Certifier (Check only one)  Certifying Physician: To the best 2 Medical Examiner: On the basis of a fid manner st                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | of examination ar                        | je, death<br>nd/or inv | occurred at the tirvestigation, in my c                 | ne, date an<br>pinion, dea              | nd place, and<br>ath occurred a | due to the ca<br>at the time, d | ause(s) and ma<br>ate and place, | nner as s<br>and due t | stated.<br>to the cause(s)                    |
|          | To t<br>To t                                                                                                                                                                 | Ž              | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0                                        |                        | 29c. Licens                                             | e number                                | 7 7                             | 29                              | 9d. Date signed                  | (Month)                | Day, Year)                                    |
|          |                                                                                                                                                                              |                | 30 Name and address of the second address of | <u> </u>                                 | /T                     | 100-                                                    | (0)                                     | 45                              |                                 | 2/14                             | 01                     |                                               |
|          |                                                                                                                                                                              |                | 30. Name and addless of person/who completed cause of c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | rar's Signature                          | 7Z                     | ass D                                                   | HA                                      | 's ENS                          | Tue-                            | V, I                             | 0 0                    | 717/2                                         |
|          | Sta<br>Registr                                                                                                                                                               |                | 31. Date filed (Month Rax Pear) 3 2008 32. Registr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | was de                                   | -                      | bronk)                                                  |                                         |                                 |                                 |                                  |                        |                                               |

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 06448 1 - For Stata Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 18, 2008 ZAIDEE NICHOLS KING 11:15 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner **QUEEN ANNE** CORSICA HILLS NURSING HOME CENTREVILLE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Worth, Day, Year) (Month, Day, Year) PENNSYLVANIA 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 🕱 F Director 220-36-1433 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r Iteme 23a or 28a-f ehow 1 Yes 2 No STEVENSVILLE QUEEN ANNE MD Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21666 200 TERRAPIN GROVE, APT. 108 Pages 1 end 2 should be filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by WHITE 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER -0-12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental MARGARET TOUHEY ROY NICHOLS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 240 HARBOR LANE, QUEENSTOWN, MD 21658 HOWARD J. KING, III/ SON item 27 i 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition CHESAPEARE CREMATION 1 ☐ Burial 2 【ICremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: If any Injury or once. 2-19-2008 STEVENSVILLE, MD CENTER 21. Signature of Funeral Service Leace FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Hofeullew 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eight line. 106 SHAMROCK ROAD, CHESTER, MD 21619 Immediate Cause (Final neemonia Physician disease or condition resulting in death) /Medical Examiner of the lung Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events physicien and s the burial-transit The law requires that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of): O. Box 68760. Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rector, page 2 s 2X No 1 Yes 1 Yes Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 45X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours e To the Funeral I completely filled o the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 1/2001

State

810

2. Registrar's Signature

30. Name and address of person who completed cause of wath (Item 23a) (Type, Print)

MDCYDW/N 31. Date filed (Month, Day, Year) FEB 1 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12:47 PM Sarah Kay Kerbin Feb 14,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Rehab + Nursing C Wicomico isbur 8 Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Numb 6. Sex Funeral Months Davs Hours 1 □ M 2 💢 F 2/4/1946 62 MD 217-44-2291 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 X No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21801 313 Carey Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Alarm Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles B. Kerbin Eleanor Smack ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Alice Collins / sister 9 Mill Landing, Millsboro, DE 19966 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 2/15/2008 Frankford, DE Cape Henlopen Crem. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau, on each fing. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4.001 disease or condition resulting in death) /Medical Duato (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 → No 3 □ Probably 4 □ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1□ Yes 2 Mo Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After to completely filled in by the funera Certification: al or Attending F s after death. (Month, Day Year) Injury 1 Hatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

1,A2

Kerbin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2008

31. Date filed (Month, Day, Year)

FEB 1

M.D.

32. Registrar's Signature

Certificate of Death

2. Date of Death

February

10

2008

U.S.A.

14. Race - American Indian

Tree Service

Black, White, etc.

Specify:

Montgomery

Maryland

Birthplace (State or Foreign Country)

Caucasian

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 ☐ Yes 2 No

4c. County of Death

3:45 pM

4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner 3 Nancy Place, Apt 4 Gaithersburg 5. Social Security Number if Under 1 Year | If Under 24 H 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ▲ M 2 ☐ F Director 215-54-9386 56 July 7, 1951 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at Director **Maryland** Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code y or 3 Nancy Place, Apt 4 "natural", or items 23a 20877 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No <u></u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Groundsman . Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If item 27 Is marked other t alury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Harvey Detro King Gertrude Melinda Melican 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. King - Wife 3 Nancy Place, Apt 4, Gaithersburg, Maryland 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 02/15/2008 Fort Lincoln Crematory Brentwood, Maryland 21. Signature of Euperal Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part1. Inter the disease, Immediate Cause (Final disease or condition resulting in death) NASOPHARYNGEA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24a. Was an autopsy page

King

1. Decedent's Name (First, Middle, Last)

Andrew

**Physician** 

/Medical

|                                |                   |                                    |                     |          | -        |                         |               |        | 24a. Was an<br>autopsy<br>performed?<br>1 Yes 2 <b>X</b> No |               | topsy findings a<br>ompletion of ca<br>2 ☐ No |      |
|--------------------------------|-------------------|------------------------------------|---------------------|----------|----------|-------------------------|---------------|--------|-------------------------------------------------------------|---------------|-----------------------------------------------|------|
| ed to medical                  |                   |                                    |                     |          |          | 26.                     | Place of Deal | th (Cf | heck only one)                                              |               |                                               |      |
| No                             | Hospital: 1 ☐ In  | patient 2                          | ER/Outpatient       | 3 🗆 [    | AOC      | Other: 4                | ☐ Nursing H   | ome    | 5 K Residence 6                                             | □Other (Spec  | ify)                                          |      |
| 5 ☐ Pending investigation      | 1                 | f Injury<br>, Day Year)            | 28b. Time of Injury | М        | ١ '      | Injury at<br>Work?<br>1 | 2 □No         | 28d.   | Describe how injury                                         | occurred      |                                               |      |
| 6 ☐ Could not be<br>determined | 28e. Place of     | of injury - At h<br>g, etc. (Speci | ome, farm, stree    | t, facto | ory, off | ice                     |               | 28f.   | Location (Street and<br>City or Town, State)                | Number or Ru  | ral Route Numi                                | ber, |
| 1 X Certifying Ph              | ysician: To the I | est of my kn                       | owledge, death of   | occurre  | ed at th | e time, d               | ate and place | and    | due to the cause(s)                                         | and manner as | stated.                                       |      |

23d. Date of delivery

Day

Year

Month

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certific

25. Was case referred to medical

1 Yes 2 No

examiner'

27. Manner of Death

1 🗷 Naturai

2 Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

29c. License number D0061083

29d. Date signed (Month, Day, Year) 12,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Thambi, M.D., 9707 Medical Center Drive, Suite 300, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) FEB 1.5 2008

State Registrar

funeral director,

within 24 hours after death To the Funeral Director:

Be

2

Certification:

Medical

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | _ State                                                                                                            | aryland / Depa                      | artment of Heritinate of Length              | ealth and M                              |                                                        |                                                                      |
|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------|------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------|
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | Registrar  1. Decedent's Name (First, Middle, Last)                                                                |                                     | runcate of L                                 | Jealii                                   | Reg. No                                                | 3. Time of Death                                                     |
|                                               | Physici<br>/Media                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | Christ William K                                                                                                   | (yriazis                            |                                              |                                          | Month Da                                               |                                                                      |
|                                               | Examir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | 4a. Facility Name (If not institution, give street and number,                                                     |                                     | 4b. City, Town, or                           | - 1                                      | 4c                                                     | County of Death                                                      |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | 5. Social Security Number 6. Sex 7. Ac                                                                             | no //n uso food himb to A           | If Under 1 Year                              | If Under 24 Hrs.                         |                                                        | nontromery                                                           |
| L                                             | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |               | 170-16-3259 1⊠ M 2□ F                                                                                              | ge (In yrs. last birthday)  88 Yrs. | Months Days                                  | Hours Min.                               | 8. Date of Birth<br>(Month, Day, Year)<br>October 23,1 |                                                                      |
|                                               | ow ow                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               | Usual Residence of Decedent  10a. State 10b. County                                                                | 10c. City, Town or Lo               | ocation                                      |                                          |                                                        | 10d. Inside City Limits                                              |
|                                               | Mary<br>1-1 sh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | tor           | Maryland Montgomery                                                                                                |                                     | Che                                          | vy Chase                                 |                                                        | 1 ☐ Yes 2 🛣 No                                                       |
|                                               | th the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Director      | 10e. Street and Number                                                                                             |                                     | 10f. Zip Code                                | .,                                       | 10g. Cit                                               | tizen of What Country?                                               |
|                                               | 23e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ral           | 8610 Grubb Road                                                                                                    |                                     |                                              | 20815                                    |                                                        | U.S.A.                                                               |
|                                               | ltems                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Funeral       | 11. Marital Status 12. Was Decedent Armed Forces:                                                                  | ?                                   | Was Decedent of His<br>If Yes, specify Cubar | spanic Origin? (Sp<br>n, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)                       | 14. Race - American Indian,<br>Black, White, etc.                    |
| 36                                            | 72 hours after death with the Maryland<br>neturel; or Items 23e or 28e-1 show<br>lical Evar in withoust ke rodified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | by F          | 1 X Never Married 2 ☐ Married 1 X Yes 2 ☐ If Yes, Give Year or Dates:                                              |                                     | 1 ☐ Yes 2 🕱 No                               | Specify:                                 |                                                        | Specify: White                                                       |
| 21215-0036                                    | 2 hou                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ted           | 15. Decedent's Education                                                                                           | WWII 16a. Deced                     | dent's Usual Occupa                          | tion                                     | 16b. K                                                 | ind of Business/Industry                                             |
| 21                                            | thin 7<br>e.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | nple          | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or                                 | lite. I                             | kind of work done du<br>DO NOT use retired)  | uring most of work                       | ing                                                    |                                                                      |
| 21                                            | ygien<br>ygien<br>t. It.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Completed     | 5+                                                                                                                 |                                     | Profe                                        | essor                                    |                                                        | Education                                                            |
| Maryland                                      | lbe fil<br>ntal H<br><b>bd ott</b><br>even                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Be            | 17. Father's Name (First, Middle, Last)                                                                            |                                     |                                              |                                          | e (First, Middle, Maiden                               |                                                                      |
| Ž                                             | hould<br>d Mer<br>marke<br>metic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2             | William P. Kyriazis  19a. Informant's Name/Relationship (Type, Print)                                              | 10b Mailie                          | a Address (Street o                          |                                          | nasia Kartsona                                         |                                                                      |
| <u>≅</u>                                      | od 2 s<br>Ith an<br>27 is i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               | Evangeline K. Haris - Sister                                                                                       |                                     |                                              |                                          | Spring, Maryla                                         | or Town, State, Zip Code)                                            |
| ē,                                            | s 1 ar<br>f Hea<br>item                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               | 20a. Method of Disposition                                                                                         | 20b. Place of Dispo                 | sition (Name of                              |                                          |                                                        | ocation - City or Town, State                                        |
| altimore,                                     | Page<br>ient o<br>nt: If<br>ry or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | 1 ☑ Burial 2 ☐ Cremation 3 ☑Removal from State  `4 ☐ Donation 5 ☐ Other (Specify)                                  | Glenwood                            | natory or other place<br>Cemetery            | ·                                        | 5/2008 Wash                                            | nington, D.C.                                                        |
| Balti                                         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and Health and H |               | 21. Signature of Funeral Service Licensee                                                                          | 22                                  | 2. Name and Address<br>lines-Rinald:         | of Facility                              |                                                        | ingeon, Deo.                                                         |
| _                                             | <u> </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               | Nancy A. Varcan                                                                                                    |                                     | 1800 New Hai                                 | mpshire Ave                              | enue, Silver S                                         | Spring, Maryland 20904                                               |
| Ш                                             | Alexander .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               | 23a. Part1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each li | rje.                                |                                              |                                          |                                                        | Approximate<br>Interval Between<br>Onset and Death                   |
|                                               | nysician<br>/Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 8 4           | Immediate cause (Final disease of condition resulting in death)                                                    | Engive s                            | condiov                                      | age ula                                  | 1 250051                                               | DMA                                                                  |
|                                               | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               | Dee to (or as                                                                                                      | a consequence of):                  |                                              |                                          |                                                        |                                                                      |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ner           | Sequentially list conditions, if any learning lists conditions.  Due to for as cause. Enter Underlying             | a consequence of):                  |                                              |                                          |                                                        |                                                                      |
|                                               | licate be executed<br>physician and<br>s the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Examiner      | Cause (Disease or injury that initiated events                                                                     |                                     |                                              |                                          |                                                        |                                                                      |
| 90                                            | oe exe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | I Ex          | resulting in death) Last Due to (or as                                                                             | a consequence of):                  |                                              |                                          |                                                        |                                                                      |
| 68760                                         | cate b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | edical        | d                                                                                                                  |                                     |                                              |                                          |                                                        |                                                                      |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | IF FEMALE: 23c. If yes, outcome                                                                                    | of pregnancy                        |                                              |                                          |                                                        | Old Date of delice                                                   |
| Вох                                           | The faw requires that the death certilite has been signed by the attending age 2 should be detached for use a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Physician/M   |                                                                                                                    | 2 Fetal death 3                     | Ectopic pregnancy Other (specify)            |                                          |                                                        | 23d. Date of delivery  Month Day Year                                |
| о.<br>О                                       | res that the de<br>signed by the a<br>be detached t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | hysi          | 9 Unknown                                                                                                          |                                     |                                              |                                          |                                                        |                                                                      |
| ις.                                           | gned<br>gned                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | by P          | Part II. Other significant conditions contributing to death b                                                      | ut not resulting in the ur          | nderlying cause giver                        | n in Part I.                             | 23e. Did tobacco u                                     | use contribute to the cause of death?                                |
| Records,                                      | w require<br>been signature<br>should b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               |                                                                                                                    |                                     |                                              |                                          | 1 ☐ Yes 2                                              | □No 3□ Probably 4 Unknown                                            |
| ပ္ပ                                           | has be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Completed     |                                                                                                                    |                                     |                                              |                                          | 24a. Was an autopsy                                    | 24b. Were autopsy findings available prior to completion of cause of |
|                                               | CG LL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Con           |                                                                                                                    |                                     |                                              |                                          | performed?<br>1 ☐ Yes 2 Z No                           | death?                                                               |
| Vital                                         | Physicien: Th<br>rthis certificate<br>ral director, pag                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Be            | 25. Was case referred to medical examiner? Hospital:                                                               |                                     |                                              | 26. Place of Death                       |                                                        |                                                                      |
|                                               | this al di                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | . To          | Yes 2 No Pospital: 1 □ Inpatie  27. Manner of Death 28a. Date of Inju                                              |                                     | t 3 DOA                                      | 4 Nursing Hor                            | me 5  esidence (28d. Describe how injur                |                                                                      |
| Division of                                   | th.<br>: After<br>funer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ertification: | 1 Natural 5 Pending (Month, Da                                                                                     | y Year) Injury                      | 28c. Injury a<br>Work?<br>M 1 7 Ye           | es 2 □ No                                | Edd. Describe flow injur                               | y occurred                                                           |
| <u>                                      </u> | Attendi<br>ir death.<br>ector: A<br>by the fu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ifica         | 3 Suicide 6 Could not be determined 28e. Place of Inj                                                              | ury - At home, farm, stre           |                                              |                                          |                                                        | d Number or Rural Route Number,                                      |
| בֿ                                            | s afte                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Cert          | 4 Homicide Stemming building, etc                                                                                  | s. (Specify)                        |                                              |                                          | City or Town, State                                    | )                                                                    |
|                                               | lo the hospitel or Attentwithin 24 hours after dealt To the Funerel Director: completely filled in by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | edical (      | 29a. Certifier (Check only con)  Medical Examiner: On the basis of                                                 | of my knowledge, death              | occurred at the time                         | , date and place, a                      | and due to the cause(s)                                | and manner as stated.                                                |
|                                               | the f                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Med           | and manner sta                                                                                                     | ited.                               |                                              |                                          |                                                        |                                                                      |
|                                               | - F G                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               | 29b. Stanature and title of certifier                                                                              |                                     | 29c. License                                 |                                          |                                                        | te signed (Month, Day, Year)                                         |
| 15                                            | ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ll J          | 30. Name and address of person who completed cause of d                                                            | 10 Omt                              | 1000                                         | 728                                      | Sel                                                    | 13 2008                                                              |
| 1                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | SOLD TRAINER AND ADDIESS OF DEFSOR WHO COMPLETED CAUSE OF A                                                        | eath (item 23a) (Type, F            |                                              |                                          | DELLE ALL MAR                                          |                                                                      |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | IRA N BERRILOU                                                                                                     | no nmt                              | Print) 2/1/2                                 | Same                                     | me mm                                                  | 209-1                                                                |
| 100                                           | Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | te            | IRA N Prechet M<br>31. Date filed (Month, Day, Year)<br>FEB 1 4 2008                                               | 100mE                               | 31/Ve                                        | Sprc                                     | me mo                                                  | 2092                                                                 |

|                            |                                                                                                                                                                                                                                                                                                                                                                                                         |                   | _ For                                                                                                                                                                  | Type or Print in I<br>State of Marylar                                                          |                                    |                                                                         |                                                       | -                                      |                                   | gible.                                            |                                                    |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------|-----------------------------------|---------------------------------------------------|----------------------------------------------------|
|                            |                                                                                                                                                                                                                                                                                                                                                                                                         |                   | 1 - State<br>Registrar                                                                                                                                                 |                                                                                                 | Cei                                | rtificate of                                                            | Death                                                 |                                        | Reg. No.                          | 008                                               | 06452                                              |
|                            | Physici                                                                                                                                                                                                                                                                                                                                                                                                 | an                | 1. Decedent's Name (First, Middle, La<br>Georgia Mae                                                                                                                   | •                                                                                               |                                    |                                                                         |                                                       | 2. Date of D<br>Month<br>02            | Day                               | Year                                              | 3. Time of Death                                   |
| in.                        | /Medic                                                                                                                                                                                                                                                                                                                                                                                                  | cal               | <u> </u>                                                                                                                                                               | King                                                                                            |                                    | # 635 T                                                                 |                                                       |                                        | 14                                | 2008                                              | 14:57 M                                            |
|                            | Examir                                                                                                                                                                                                                                                                                                                                                                                                  | ier               | 4a. Facility Name (If not institution, give Southern Md Hosp                                                                                                           | oital                                                                                           | 1-11:11:1                          | 4b. City, Town, Clir                                                    |                                                       |                                        | Prin                              | unty of Death                                     | orges                                              |
| <b>.</b>                   | Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                     |                   | 5. Social Security Number 6. S 577–56–4184 1                                                                                                                           | T. Age (In yrs. 76 76                                                                           | Yrs.                               | Months Days                                                             |                                                       |                                        | lay, Year)                        | 9. Birth<br>Cou<br>Sout                           | place (State or Foreign<br>ntry)<br>Ch Carolina    |
|                            | e Maryland<br>8a-f show<br>tified at                                                                                                                                                                                                                                                                                                                                                                    | ctor              | 10a. State 10b. County Prince C                                                                                                                                        |                                                                                                 | ty, Town or Lo<br>itland           | cation                                                                  |                                                       |                                        |                                   |                                                   | 10d. Inside City Limits  Y Yes 2 □ No              |
|                            | th with th<br>23a or 24<br>ust be no                                                                                                                                                                                                                                                                                                                                                                    | Funeral Director  | 10e. Street and Number 3940 Bexley Place                                                                                                                               | æ                                                                                               |                                    | 10f. Zip Code                                                           | 20746                                                 |                                        | 10g. Citizen<br>US                | of What Cou<br>SA                                 | ntry?                                              |
| 980                        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fijury or other traumatic event, the Medical Examiner must be notified at once.                                                                                                        |                   | 11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced                                                                                             | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 M No<br>If Yes, Give<br>Year or Dates: | 1                                  | Was Decedent of<br>If Yes, specify Cul<br>1 □ Yes 2X No                 | Hispanic Origin? (S<br>ban, Mexican, Puer<br>Specify: | Specify Yes or N<br>to Rican, etc.)    |                                   | Race - Ameri<br>Black, White,<br>ecify:Blac       | etc.                                               |
| 21215-0036                 | within 72 ho<br>lene.<br>than "natu<br>the Medical                                                                                                                                                                                                                                                                                                                                                      | Completed by      | 15. Decedent's Et (Specify only highest grade) Elementary/Secondary (0-12)                                                                                             | ducation<br>ide completed)  College (1-4or 5+)                                                  | (Give<br>life, L                   | dent's Usual Occu<br>kind of work done<br>DO NOT use retire<br>Od Servi | during most of wo<br>ed)                              | rking                                  | Ĩ                                 | of Business/Ir<br>.vate                           | ndustry                                            |
| <b>d</b> 2                 | e filed all Hygie<br>other i                                                                                                                                                                                                                                                                                                                                                                            | ပို               | 17. Father's Name (First, Middle, Last,                                                                                                                                | )                                                                                               | 1 20                               |                                                                         | 18. Mother's Nar                                      | me (First, Middle                      | e, Maiden Sur                     | name)                                             |                                                    |
| <u>lan</u>                 | buld be<br>Mental<br>arked o<br>atic eve                                                                                                                                                                                                                                                                                                                                                                | To Be             | George Renwrick                                                                                                                                                        | :                                                                                               |                                    |                                                                         | Nancy                                                 | Frankli                                | n                                 |                                                   |                                                    |
| , Maryland                 | is 1 and 2 should be<br>of Health and Menta<br>item 27 is marked i<br>other traumatic ev                                                                                                                                                                                                                                                                                                                |                   | 19a. Informant's Name/Relationship (<br>Dianna Mathews                                                                                                                 | Type. Print)<br>Daughter                                                                        | 19b. Mailin<br>7301                | ng Address (Stree<br>Glendo                                             | t and Number or Ri                                    | ural Route Num<br>Forestvi             | ber, City or To<br>lle, M         | wn, State, Zij<br>ID 207                          |                                                    |
| Baltimore,                 | permit. Pages 1 an<br>Department of Heal<br>Important: If item 2<br>any Injury or other<br>once.                                                                                                                                                                                                                                                                                                        |                   | 20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 X 4 ☐ Donation 5 ☐ Other (Specif                                                                                 | Removal from State                                                                              | cemetery, crer                     | sition (Name of<br>matory or other pla<br>Cemeter                       | y 02/2                                                | Date 22/2008                           | 1                                 | on - City or T<br>Hill,                           |                                                    |
| l Balt                     | permit<br>Depart<br>Import<br>any inj                                                                                                                                                                                                                                                                                                                                                                   |                   | 21. Signature of Funeral Service Lies                                                                                                                                  | isee                                                                                            |                                    | 2. Name and Addr<br>Bianchi                                             | ess of Facility<br>814 Upsl                           | nur St N                               | W Was                             | h, DC                                             | 20011                                              |
|                            | Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                       |                   | 23a. Part1. Enter the disease, or com shock, or head tall re. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. | a. Due to (or as a consect                                                                      | LCa<br>quence of):                 |                                                                         | ing, such as cardia                                   |                                        |                                   |                                                   | Approximate<br>Interval Between<br>Onset and Death |
| ,092                       | eath certificate be executed attending physician and for use as the burial-transit                                                                                                                                                                                                                                                                                                                      | cal Examiner      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             | C                                                                                               |                                    |                                                                         |                                                       |                                        |                                   |                                                   |                                                    |
| P.O. Box 687               | To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after clearly. Within 24 hours after death this certificate has been signed by the attending physicial To the Tuneral Discorptions. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                                                                | 23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown        | aldeath 3□                         | Ectopic pregnand Other (specify)                                        | ру                                                    |                                        | 23d.                              | Date of deliv<br>Month                            | ery<br>Day Year                                    |
|                            | uires that the de<br>signed by the a<br>ld be detached f                                                                                                                                                                                                                                                                                                                                                | þ                 | Part II. Other significant conditions of                                                                                                                               | ontributing to death but not res                                                                | sulting in the ur                  | nderlying cause gi                                                      | ven in Part I.                                        |                                        | tobacco use o                     |                                                   | the cause of death?                                |
| Division or Vital Records, | ding Phystotan: The law require<br>n.<br>After this certificate has been siç<br>funeral director, page 2 should b                                                                                                                                                                                                                                                                                       | Completed         |                                                                                                                                                                        |                                                                                                 |                                    |                                                                         |                                                       |                                        | s an 24<br>opsy<br>ormed?<br>2 No | 4b. Were auto<br>prior to co<br>death?<br>1 □ Yes | opsy findings available ompletion of cause of 2 No |
| Vita                       | iclan: Th<br>certificate<br>rector, pag                                                                                                                                                                                                                                                                                                                                                                 | Be                | 25. Was case referred to medical examiner?                                                                                                                             | Hospital:                                                                                       |                                    | 100                                                                     | 26. Place of Dea                                      | ath (Check only                        | one)                              | e*                                                |                                                    |
| 0                          | ding Phys<br>T.<br>After this<br>funeral dir                                                                                                                                                                                                                                                                                                                                                            | 2                 | 1 ☐ Yes 2 No 27. Manner of Death                                                                                                                                       | 1 ☐ Inpatient 2                                                                                 | ER/Outpatien<br>28b. Time of       | I SUIDON                                                                |                                                       | fome 5 ☐ Res                           |                                   |                                                   | fy)                                                |
| sion                       | tending<br>leath.<br>tor: Aftel<br>the fune                                                                                                                                                                                                                                                                                                                                                             | Certification:    | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be                                                                                          | (Month, Day Year)                                                                               | Injury                             | M 1□                                                                    | Yes 2 No                                              |                                        |                                   |                                                   |                                                    |
| <u> </u>                   | To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the                                                                                                                                                                                                                                                                                                |                   | 4 Homicide determined                                                                                                                                                  | building, etc. (Speci                                                                           | fy)                                |                                                                         |                                                       | City or To                             | iwn, State)                       |                                                   | al Route Number,                                   |
|                            | To the Hospital within 24 hours To the Funeral completely filled                                                                                                                                                                                                                                                                                                                                        | edical            | (Check only one) 2 Medical Exam                                                                                                                                        | ysician: To the best of my kno<br>niner: On the basis of examina<br>and manner stated.          | owledge, death<br>ation and/or inv | vestigation, in my                                                      | opinion, death occ                                    | e, and due to the<br>urred at the time | e cause(s) and<br>e, date and pla | d manner as s<br>ice, and due t                   | stated.<br>to the cause(s)                         |
| )                          | To the within To the compli                                                                                                                                                                                                                                                                                                                                                                             | N                 | 29b. Signature and title of certifier                                                                                                                                  | W,MO                                                                                            |                                    | 29c. Licen                                                              | se number                                             | ر<br>در                                | 29d. Date sig                     | gned (Month,                                      | Day, Year)                                         |
| 1                          | 26                                                                                                                                                                                                                                                                                                                                                                                                      |                   | 30. Name and address of person who SANDLA BANKS                                                                                                                        |                                                                                                 | n 23a) (Type, I                    | Print)                                                                  | CLINTON.                                              |                                        | 2073                              | 5                                                 |                                                    |
| Ser. Ser.                  | Sta<br>Registr                                                                                                                                                                                                                                                                                                                                                                                          |                   | 31. Date filed (Month, Day, Year)<br>FEB 1 9 2008                                                                                                                      | 32. Registrar's Sign                                                                            | ture                               |                                                                         |                                                       |                                        |                                   |                                                   |                                                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 12 36 PM Stephen Joseph Lesnick FEBRUARY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE AGNES HOSPITAL None If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**X** M 2 □ F Yrs. Director 72 Maryland Jan 23, 1936 220 30 5735 Usual Residence of Decedent 10a, State 10c. City, Town or Location f show 10b. County 10d. Inside City Limits an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 1 □Yes 2X No Directo MD Elkridae Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6155 Shadywood Road Unit 401 21075 United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 157 Yes 2 No If Yes, Give Year or Dates: unknown 1 Never Married 3 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Inspector BGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Steve Lesnick Agnes unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary K. Lesnick/Wife 6155 Shadywood Road Unit 401 Elkridge, MD 21075 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem. 2-16-2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Shem Ollis 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART /Medical Due to (or as a consequence of) Examiner SCHEMIC CARDIOMYOPATHY 22 YEARS Securificity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami burial-trar Due to (or as a consequence of) the attending physician hed for use as the buria Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) o detached 9□Unknown 9 Unknown 5 م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ RENAL FAILURE CHRONIC 1 Yes 2 No 3 Probably 4 Munknown page 2 should Completed been : 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No DIABETES MELLITUS 24a. Was an certificate has autopsy performed HYPERTENSION Vital 1□ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ō 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Attending 5 Pending investigation Injury 1 X Natural To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No death 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

(5 +1

PHI

State Registra

900 31. Date filed (Month, Day, Year) FEB 19 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

KWAME

NTIM



MEDICAL DOCTOR

29c. License number

BALTIMORE

P20805

29d. Date signed (Month, Day, Year)

FEBRUARY

21229

MD

14 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month .Orger beaum 2008 JRANVILLE 9:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Laurel Regional Hospital Laurei Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Apr 25, 19 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days **™** M 2 F Yrs. Director 579 01 5137 96 West Virginia 1911 Usual Residence of Deceden 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Items 23a 5330 Dorsey Hall Drive #306 21042 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after on Hygiene.
I Hygiene. 1 ∑Yes 2 No If Yes, Give Year or Dates: 1943-45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Purchasing Clerk Bethlehem Steel permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any linky or other treumstic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles R. Longerbeam Bertie V. Cogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Gulyas/Niece 9 Moonshell Drive Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) St. Johns Cemetery 2-18-2008 Ellicott City, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Oll 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to loras a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transit Ken resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy ŏ Month 4☐Pregnant at time of death signed by the at the detached to 5 Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably Soknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 Yes 1 Tyes within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ Other: 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) R/Outpatient 3 DOA 27. Manner of Dear 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitat o within 24 hours aft To the Funeret Di Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signatur 29c. License numbe 29d. Date signed (Month, Day, Year) +1 person who completed cause of death (Item 23a) (Type, Print) 700 CHANTER 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 1 9 2008 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                |                                                                                                                                                                                                                               | •              | For State Of IVIS                                                                                                               |                            | artment of Health and rtificate of Death                                       | , ,                                                 | ne<br>No2008                                | 06455                                              |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------|----------------------------------------------------|
|                | Physicia                                                                                                                                                                                                                      |                | 1. Decedent's Name (First, Middle, Last)  Francisco Herminio Laurie                                                             | er                         |                                                                                | 2. Date of Death<br>Month<br>February               | Day Year 10, 2008                           | 3. Time of Death 14:45                             |
|                | /Medic<br>Examin                                                                                                                                                                                                              | _              | 4a. Facility Name (If not institution, give street and number)                                                                  |                            | 4b. City, Town, or Location of Dea                                             |                                                     | 4c. County of Death                         |                                                    |
|                |                                                                                                                                                                                                                               | н              | Anne Arundel Medical Center  5. Social Security Number 6. Sex 7. Ag                                                             | e (In yrs. last birthday)  | Annapolis  If Under 1 Year   If Under 24 Hrs                                   | 8. Date of Birth                                    |                                             | Arundel                                            |
| H              | Funeral<br>Director                                                                                                                                                                                                           |                | 119–34–6225                                                                                                                     | 65 Yrs.                    | Months Days Hours Min                                                          |                                                     | 1942                                        | place (State or Foreign<br>intry)<br>Cuba          |
|                | yland<br>low<br>at                                                                                                                                                                                                            |                | Usual Residence of Decedent  10a. State 10b. County                                                                             | 10c. City, Town or Lo      | cation                                                                         |                                                     |                                             | 10d. Inside City Limits                            |
|                | e Mar<br>3a-f sh<br>tified                                                                                                                                                                                                    | ctor           | Maryland Anne Arundel                                                                                                           |                            | Annapolis                                                                      |                                                     |                                             | 1 XYes 2 No                                        |
|                | 3a or 28<br>st be no                                                                                                                                                                                                          | Il Director    | 10e. Street and Number 941 King James Landing Roa                                                                               | .d                         | 10f. Zip Code <b>21403</b>                                                     | 10g.                                                | U.S.A.                                      |                                                    |
|                | ems 2                                                                                                                                                                                                                         | Funeral        | 11. Marital Status 12. Was Decedent Armed Forces?                                                                               | Ever in U.S. 13.           | Was Decedent of Hispanic Origin? (<br>If Yes, specify Cuban, Mexican, Pue      | Specify Yes or No-<br>rto Rican, etc.)              | 14. Race - Amer<br>Black, White             |                                                    |
| 030            | be filed within 72 hours after death with the Maryland thygiene. Hygiene. do they than "natural"; or items 23a or 28a-f show other than "natural"; or items 23a or 28a-f show event, the Medical Examiner must be notified at | þ              | 1 XX Sever Married 2 Married 1                                                                                                  | No                         |                                                                                | Cuban                                               | Specify: Wh                                 |                                                    |
| 2-0036         | 72 ho<br>"natur<br>dical                                                                                                                                                                                                      | eted           | 15. Decedent's Education<br>(Specify only highest grade completed)                                                              | ı (Give                    | dent's Usual Occupation<br>kind of work done during most of we                 | orking 16t                                          | o. Kind of Business/I                       | ndustry                                            |
| 2              | within<br>ene.<br>than '                                                                                                                                                                                                      | Completed      | Elementary/Secondary (0-12) College (1-4or 5                                                                                    | 1.1                        | DO NOT use retired)<br>tect & Interior I                                       | Designer                                            | Architect                                   | ure                                                |
| andz           | e filed<br>al Hygi<br>other<br>vent, th                                                                                                                                                                                       | BeC            | 17. Father's Name (First, Middle, Last)                                                                                         |                            |                                                                                | rme (First, Middle, Mai                             | ,                                           |                                                    |
| ylar           | should be<br>and Mental<br>s marked o<br>umatic eve                                                                                                                                                                           | 2              | Francisco Lorie                                                                                                                 |                            |                                                                                | ga Esquijar                                         |                                             |                                                    |
| Mar            | C1 00 00 00                                                                                                                                                                                                                   |                | 19a. Informant's Name/Relationship (Type. Print)  Michael G. Dufton/partner                                                     |                            | ng Address <i>(Street and Number or F</i><br>ing James Landino                 |                                                     | ity or Town, State, Z<br>napolis, M         |                                                    |
| ē,             | es 1 and<br>of Health<br>of Item 27<br>r other to                                                                                                                                                                             |                | 20a. Method of Disposition                                                                                                      |                            | osition (Name of matory or other place)                                        |                                                     | c. Location - City or                       |                                                    |
| <u> </u>       | Pages<br>ment of<br>ant: If its<br>ury or o                                                                                                                                                                                   | 4              | 1 ☐ Burial A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)                                                  | Baltimore                  | e Crematory 2/14                                                               |                                                     | ltimore,                                    |                                                    |
| Baltimore,     | permit. Pag<br>Department<br>Important: I<br>any injury o                                                                                                                                                                     |                | 21. Sign to Funeral Service Licensee                                                                                            |                            | 2. Name and Address of Facility (                                              |                                                     |                                             |                                                    |
| ı              | 100                                                                                                                                                                                                                           |                | 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li             |                            |                                                                                |                                                     |                                             | Approximate<br>Interval Between<br>Onset and Death |
|                | Physician                                                                                                                                                                                                                     |                | Immediate Cause (Final disease or condition                                                                                     | States                     | Ca Cuna                                                                        |                                                     |                                             | Z Y Levr                                           |
|                | /Medical<br>Examiner                                                                                                                                                                                                          |                | resulting in death)  Due to (or as                                                                                              | a consequence of):         | )                                                                              |                                                     |                                             | )                                                  |
|                | ted sit                                                                                                                                                                                                                       | Examiner       | Sequentially list conditions, any leading to min-distact cause. Enter Underlying Cause (Disease or injury that initiated events | a consequence of):         |                                                                                |                                                     | -                                           |                                                    |
| oʻ.            | ificate be executed<br>g physician and<br>as the burial-transit                                                                                                                                                               |                | that initiated events resulting in death) Last C. Due to (or as                                                                 | a consequence of):         |                                                                                |                                                     |                                             |                                                    |
| 08/60          | ate be                                                                                                                                                                                                                        | edical         | d                                                                                                                               |                            |                                                                                |                                                     |                                             |                                                    |
|                | leath certific<br>attending p                                                                                                                                                                                                 | /Me            | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome                                                                      | pf pregnancy               |                                                                                |                                                     | 23d. Date of deli                           | verv                                               |
| ž<br>ROS<br>T  | death cert<br>e attending<br>ed for use a                                                                                                                                                                                     | Physician/M    | in the past 12 months?  1 Yes 2 No 9 Unknown                                                                                    | 2 Fetal death 3            | □Ectopic pregnancy<br>□ Other <i>(specify)</i>                                 |                                                     | Month                                       | Day Year                                           |
| r<br>Ö         | nat the<br>d by th<br>etache                                                                                                                                                                                                  | Phys           | 9 ☐ Unknown  Part II. Other significant conditions contributing to death b                                                      | out not reculting in the u | nderlying cause given in Part I                                                | 23a Did tohac                                       | oco use contribute to                       | the cause of death?                                |
| rds,           | w requires that the d<br>been signed by the<br>should be detached                                                                                                                                                             | þ              | Part II. Other significant conditions continuum to death t                                                                      | at not resulting in the d  | indenying cause given in Fart.                                                 | 1 X Yes                                             |                                             | obably 4 Unknown                                   |
| Vital Records, | G O O                                                                                                                                                                                                                         | Completed      |                                                                                                                                 |                            |                                                                                | 24a. Was an autopsy                                 | prior to c                                  | topsy findings available completion of cause of    |
| <u>8</u>       |                                                                                                                                                                                                                               |                | OF Man ages referred to modical                                                                                                 |                            | 00 81 (0                                                                       | performe                                            | d2 death?<br>Xuo 1 ☐ Yes                    | 2□ No                                              |
|                | Physician:<br>this certific<br>al director,                                                                                                                                                                                   | o Be           | 25. Was case referred to medical examiner? 1 ☐ Yes Pho Hospital: 1 ☐ Inpati                                                     | ent 2 ☐ ER/Outpatier       | Other                                                                          | eath (Check only one) Home 5  Residence             | ce 6 □Other (Spec                           | city)                                              |
| o uc           | ng<br>ffer<br>iner                                                                                                                                                                                                            | on: T          | 27. Manner of Death 1 Natural 5 Pending (Month, Da                                                                              | ıry 28b. Time o            | Work?                                                                          | 28d. Describe how                                   | injury occurred                             |                                                    |
| DIVISION       | Attend<br>r death.<br>ector: /<br>by the f                                                                                                                                                                                    | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of in building, e                            | ury - At home, farm, str   |                                                                                |                                                     | et and Number or Ru                         | ıral Route Number,                                 |
| 5              | ital or<br>rs after<br>ral Dire                                                                                                                                                                                               | Certi          | 4   Holling, e                                                                                                                  | tc. (Specify)              |                                                                                | City or Town, S                                     |                                             |                                                    |
|                | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,                                                              | edical         | 29a. Certifier (Check only one)  Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st            | of examination and/or in   | th occurred at the time, date and pla<br>nvestigation, in my opinion, death oc | ce, and due to the caus<br>curred at the time, date | se(s) and manner as<br>e and place, and due | stated.<br>to the cause(s)                         |
|                | To the within To the comp                                                                                                                                                                                                     | <b>X</b>       | 29b. Signature and title of certifier                                                                                           | 1.10.0                     | 29c. License number                                                            | 29d                                                 | Date signed (Mont                           | h, Day, Year)                                      |
| ,              | D all                                                                                                                                                                                                                         |                | 304 Name and address of persop who completed cause of c                                                                         | death (Item 23a) (Type,    | Print)<br>EFENSETHGHW                                                          | . 1                                                 | Jessman,                                    | 14 2008                                            |
|                | 10/12                                                                                                                                                                                                                         |                | MILHAEL J. C. EV A UM  31. Date filed (Month, Day, Year)  32. Regist                                                            | Y45 D                      | EFENSETTIGH W                                                                  | Ay HONI                                             | HOUT W                                      | 10 2140,                                           |
|                | Sta<br>Registi                                                                                                                                                                                                                |                |                                                                                                                                 | e. K. A.                   | Co. M.                                                                         |                                                     |                                             |                                                    |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February Day 0, 2008 1:54 Olaf M. Loytty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Carroll Westminster If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □**34** 2 □ F Director Sept 23 1914 93 118-01-9539 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10h. County 10d. Inside City Limits "natural", or Items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 XNo MD Carroll Westminster Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 507 High Acre Drive Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 <u>ک</u> 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) International Sales Manager Corning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown ပ unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Woerner/stepdaughter 1102 Chapel Road Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Premation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc 2/13/2008 Hampstead, MD 21. Signature of Funeral Service Licensee Princip Armetrality Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. En The disease, or complication of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ST-Elevation Myocardial Non **Physician** Inwaction /Medical Due to (or as a consequence of): Examiner Aspiration neumonia Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examiner toru Kespira physician and s the burial-tran Due to (or as a consequence of): Physician/Medical Ivemous IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performe To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dea... ral Director: Aftr 5 ☐ Pending investigation 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

WIL 10+7 29b. Signature and title of certifier

oyed 31. Date filed (Month, Day, Year)

5

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

30. Native and address of person who completed cause of death (Item 23a) (Type, Print)

Sured S. Hosain M.D. Hur, East Main St. Westminster M.D. 21157

29c. License number

D39502 MM

29d. Date signed (Month, Day, Year)

and manner stated.

MJ

32. Registrar's Signature

|                                            | 1        | For State                                                                                                                                      |                                               | State of                             | Marylar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               | epartme<br>Certifica                      |                           |                      |                              | ental Hy                                | _          | -21111                         | 3                    | 0645                                           |
|--------------------------------------------|----------|------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------|---------------------------|----------------------|------------------------------|-----------------------------------------|------------|--------------------------------|----------------------|------------------------------------------------|
|                                            | Ė        | Registrar  1. Decedent's Nam                                                                                                                   | e (First, Middle, I                           | Last)                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                           | 110 07 1                  | Jean                 |                              | 2. Date of De                           | Reg. No    | 0.== 0                         |                      | 3. Time of Death                               |
| ician<br>dical                             |          | Min Ja L                                                                                                                                       | ee                                            |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                           |                           |                      |                              | Month<br>FEB. 1                         | .2, Da     | 2008 Year                      | r                    | 5:46 A.                                        |
| niner                                      | 4        | ta. Facility Name (/                                                                                                                           | f not institution, g                          | give street and nun                  | nber)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               | 4b. C                                     | ty, Town, or              | Location             | of Death                     |                                         | 40         | c. County of De                | ath                  |                                                |
| 79                                         |          | Suburban                                                                                                                                       | -                                             |                                      | 7 4 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               |                                           | thesda                    |                      | - 04 Use T                   |                                         |            | ontgome                        |                      |                                                |
| al<br>or                                   |          | 5. Social Security N<br>155-62-70                                                                                                              | 643                                           | Sex<br>1 □ M 2 X F                   | 7. Age (In yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | last birtho                   | Month                                     | der 1 Year<br>is Days     | Hours                | Min.                         | B. Date of Bir<br>(Month, Da<br>NOV • 1 | ay, Year   | r) (                           | Sirthplac<br>Country | Korea                                          |
|                                            | -        | Usual Residence of<br>10a. State                                                                                                               | Decedent<br>10b. County                       |                                      | 10c. Ci                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ty, Town o                    | or Location                               |                           |                      |                              |                                         |            |                                | 10d                  | . Inside City Lim                              |
| Ď                                          |          | Maryland                                                                                                                                       | Montgom                                       | erv                                  | Si 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ver                           | Sprin                                     | or .                      |                      |                              |                                         |            |                                |                      | 1 □Yes 2 🔀                                     |
| Director                                   | $\vdash$ | 10e. Street and Nu                                                                                                                             |                                               |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                           | Zip Code                  |                      |                              |                                         | 10g. C     | itizen of What (               | Country              | r?                                             |
|                                            |          | 4011 Rand                                                                                                                                      | dolph Ro                                      | ad                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | 2                                         | 0902                      |                      |                              |                                         | Uni        | ted Sta                        | tes                  |                                                |
| Funeral                                    | 1        | 11. Marital Status                                                                                                                             |                                               | 12. Was Dece<br>Armed For            | dent Ever in U                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | I.S.                          | 13. Was De                                | cedent of H               | ispanic O            | rigin? (Spec<br>an, Puerto R | ify Yes or No                           | D-         | 14. Race - An<br>Black, Wh     |                      |                                                |
| J.F.                                       |          | _                                                                                                                                              | ied 2 Married                                 | 1 ☐ Yes<br>If Yes, Giv               | 2 <b>∑</b> No<br>e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               |                                           | 2 <b>X</b> No             |                      |                              | ioun, oto.,                             |            | Specify:                       |                      |                                                |
| d by                                       |          | 3 ₩ Widowed                                                                                                                                    |                                               | Year or Da                           | ites:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | T 40- D                       |                                           | 10                        |                      |                              |                                         | 10)        | A                              | sia                  |                                                |
| Completed                                  | 8        |                                                                                                                                                |                                               | grade completed)                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | i (0                          | ecedent's U<br>Give kind of<br>ife. DO NO | work done d               | during mo            | st of working                | 7                                       | 16b.  <br> | Kind of Busines                | ss/Indus             | stry                                           |
| ᄩ                                          |          | Elementary/Seco                                                                                                                                | ondary (0-12)                                 | College (1                           | -4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Ι.                            | memak                                     |                           | ,                    |                              |                                         | Own        | n Home                         |                      |                                                |
| Ö                                          | -        | 17. Father's Name                                                                                                                              | (First, Middle, La                            | st)                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                           |                           | 18. Moth             | ner's Name (                 | First, Middle                           | , Maide    | n Surname)                     |                      |                                                |
| 0.0                                        |          | Kyu S. Le                                                                                                                                      | ee                                            |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                           |                           | Jong                 | , O. K                       | im                                      |            |                                |                      |                                                |
| -                                          | r        | 19a. Informant's N                                                                                                                             | ame/Relationship                              | (Type. Print)                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 19b. N                        | Aailing Addr                              | ess (Street               | and Numl             | ber or Rural                 |                                         | er, City   | or Town, State                 | , Zip C              | ode)                                           |
|                                            |          | Kyung Lee                                                                                                                                      | e, Daugh                                      | ter                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | 56 Me<br>nesvi                            |                           |                      |                              |                                         |            |                                |                      |                                                |
|                                            | 12       | 20a. Method of Disp                                                                                                                            | •                                             | XIRemoval from S                     | 20b.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Place of D<br>cemetery,       | isposition (I crematory                   | lame of<br>or other place |                      | FEB. Da                      | та.                                     | 20c. l     | Location - City of             | or Town              | n, State                                       |
|                                            |          |                                                                                                                                                | 5 ☐ Other (Spe                                |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | lrfax                         | Memo                                      | cial I                    |                      |                              |                                         | Fa         | irfax,                         | Vir                  | ginia                                          |
| once.  To Be Completed by Funeral Director |          | 21. Signature of Fu                                                                                                                            | uneral Service Lic                            |                                      | M015                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 508                           | Fair:                                     |                           | emori                | lal Fu                       |                                         |            | e<br>VA 220                    | 22                   |                                                |
| dical Examiner                             |          | resulting in death) Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) i | nmediate<br>erlying<br>injury                 | b. Corons Due to (                   | or as a consecutive ary Art or as a consecutive or as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a consecutive as a c | ery<br>quence of)             | Disea:                                    | se                        |                      |                              |                                         |            |                                |                      |                                                |
| hysician/Me                                |          | IF FEMALE:<br>23b. Was deceden<br>in the past 12<br>1 ☐ Yes 2<br>9 ☐ Unknown                                                                   | months?                                       |                                      | rth 2 Feta<br>ant at time of c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | al death                      | 3 □Ectopie<br>5 □ Other                   | pregnancy<br>(specify)    |                      |                              |                                         |            | 23d. Date of d<br>Month        | delivery<br>Da       |                                                |
| by P                                       |          | Part II. Other signi                                                                                                                           |                                               | s contributing to de                 | ath but not res                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | sulting in th                 | ne underlyin                              | g cause give              | en in Part           | l.                           | 23e. Did                                | tobacco    | use contribute                 | to the               | cause of death?                                |
| ed                                         | j.       | Hypertens                                                                                                                                      | sion                                          |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                           |                           |                      |                              | 1 🗆                                     | Yes 2      | 2 No 3                         | Probab               | oly 4 <b>X</b> iUnkno                          |
| ompleted                                   | -        |                                                                                                                                                |                                               |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                           | -                         |                      |                              | 24a. Was<br>auto<br>perf                |            | prior to                       | o comp               | y findings availa<br>letion of cause o<br>🕅 No |
| O e                                        | -        | 25. Was case refer                                                                                                                             | red to medical                                |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |                                           |                           | 26. Plac             | ce of Death (                |                                         |            | 10 1016                        | CS 2                 | 23 140                                         |
| To B                                       |          | examiner?<br>1 ☐ Yes 2 <b>X</b>                                                                                                                | No                                            | Hospital: 1 🔲 Ir                     | npatient 2 🕽                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ER/Outpa                      | atient 3                                  | DOA Othe                  | or:                  |                              |                                         |            | 6 □Other (Sp                   | pecify)              |                                                |
| Certification:                             | 4        | 27. Manner of Deat  1  Natural  2  Accident  3  Suicide  4  Homicide                                                                           | th 5 Pending investigat 6 Could not determine | be 28e. Place                        | of Injury<br>h, Day Year)<br>of injury - At h<br>lg, etc. (Speci                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 28b. Tin<br>Inju<br>ome, farm | ury<br>M                                  |                           | yat<br>k?<br>Yes 2 ⊑ | ]No                          |                                         | Street a   | ury occurred and Number or te) | Rural F              | Route Number,                                  |
| edical Cer                                 |          | 29a. Certifier<br>(Check only<br>one)                                                                                                          |                                               | Physician: To the saminer: On the ba | sis of examina                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               |                                           |                           |                      |                              |                                         |            |                                |                      |                                                |
| Me                                         |          | 29b. Signature and                                                                                                                             | Can K                                         | o completed cause                    | of death (Iter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 7<br>m 23a) (Ty               | cp.                                       | 29c. License<br>D5226     |                      |                              |                                         |            | ate signed (Mo                 |                      | ay, Year)                                      |
|                                            | _        | Alan R. S                                                                                                                                      |                                               | .D., 151                             | Hugo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Circ                          | 1e, S:                                    | ilver                     | Spri                 | ng, M                        | D 2090                                  | 6          |                                |                      |                                                |
| State<br>strar                             | 1        | 31. Date filed (Mon                                                                                                                            | th, Day, Year)                                | 2003                                 | egistrar's Sign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ature                         | Sports                                    | 9                         |                      |                              |                                         |            |                                |                      |                                                |
| 1/2001                                     |          |                                                                                                                                                |                                               |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | -                             |                                           |                           |                      |                              |                                         |            |                                |                      |                                                |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician**  $2:35 a^{M}$ Pathma Μ. Liyanapathirana February 13, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charter House Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral**  Date of Birth (Month, Day, Year) Months Days Hours 1 M 2 F 579-68-8742 73 Director 3, 1934 Nov. Sri Lanka Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 10b. County 1 XYes 2 ☐ No Directo D.C. Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a or Examiner must be r 4419 35th Street, NW 20008 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 3€ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 文 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No <u>م</u> Specify Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Director of School Montessori Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of the stand that the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard George Liyanapathirana Susannah Kaluaratchi ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sardha P. Kaluaratchi/Cousin 4419 35th Street, NW, Washington, DC 20008 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Feb. 15 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Alexandria, Virginia 5 ☐ Other (Specify) Metropolitan Crematory 2008 4 □ Donation 21. Signatur of Funeral Service Lie 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. e 0 500 University Blvd, W. Silver Spring, MD 20901 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Widely Metastatic Breast Cancer 8 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 aftending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9∏Unknown 9 ☐ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) e Hospital or Attending Pl 24 hours after death. e Funeral Director; After the 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Living 1 🔼 Natural 5 Pending investigation Injury 1☐ Yes 2☐No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only To the I within 24 To the F one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) d37236 February 13, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carolyn B. Hendricks MD 6410 Rockledge Drive, #506, Bethesda, MD 20817 31. Date filed (Month, Day, Year) FEB 14 32 Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician FEB 11 2008 2:40 A M THOMAS PETER LANTOS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER **BETHESDA** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 4. Month, Day, Social Security Number 535 - 28 - 3598 7. Age (In yrs last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Months Yrs. Feb. Hungary Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notifled at 1 X Yes 2 □ No Washington Director DC 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20002 United States Funeral Justice Court, NE 228 B death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: White <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Congressman 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Halasz Department of Health and Ment Important: If item 27 is marker any Injury or other traumatic e Paul Lantos ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 20003 1415 Potomac Avenue, SE, Washington, DC Tomicah Tillemann, Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 02/15/08 Alexandria, VA 21. Signature of Fundial Stylice accessed 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC ESOPHAGEAL CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it is a ling to improve that cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1∐ Yes 2 X No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No ၉ 1 XInpatient 2 ER/Outpatient 3 DOA this funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After t 1X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No ie Hospital or Attendi 24 hours after death. ie Funeral Director: A death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Technitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0102202116 (VA) NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 LT USN ROBERT T. DENDALL MC 31. Date filed (Month, Day, Year)

State Registrar FEB 1 4 2008 32 Registrar's



State Registrar

31. Date filed (Month, Day, Year) 2008 FEB 19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 10:30 PM 15, 2008 REGINALD LEE MORGAN February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Alice Byrd Tawes Nursing Home Crisfield Somerset If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 X M 2 □ F Yrs Maryland 82 Nov. Director 216-20-0047 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location r 28a-f show notified at 1 ☐ Yes 2 X No Director Crisfield Maryland Somerset 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number must be n 21817 USA 26431 Old State Road Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If frem 27 is marked other than any Injury or other trainment. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items dical Examiner mu Black, White, etc. 1XYes 2□NºWorld IfYes, Give Year or Dates: War II 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 X No à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bread Company Supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barney Bayne Morgan Evelyn Dize ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26431 Old State Road - Crisfield, Maryland 21817 of Disposition (Name of Date | 20c. Location - City or Town, State <u>Jeanette Morgan (Wife)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBunal 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Sunnyridge Memorial Park Feb. 20, 2008 Crisfield, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BRADSHAW & SO Mary Beth Bradshaw-Pruitt 306 W. Main Street - Crisfic 23a. Parl Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 ☐ Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ DEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a 💢 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

DHMH 17 Rev 1/2001

within 2

- 201 Hall Highway - Crisfield, MD 21817 Vijay Karumbunathan, 31. Date filed (Month, Day, Year) MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2003

and manner stated.

FEB 19 Registrar

29b. Signature and title of certifier

29c. License number

48098

29d. Date signed (Month, Day, Year)

2008

118

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:55 P<sup>M</sup> 2008 Charles Robert Mead February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1[**X**M 2□ F Director 72 July 27,1935 Maryland 215 32 6074 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director MD Woodbine Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3318 Hipsley Mill Rd 21797 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Byes 2 No If Yes, Give Year or Dates: unknown 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify. Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Auto Dealers Automotive Field 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles August Mead Grace Virginia Morgan ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3318 Hipsley Mill Rd Woodbine, MD 21797 Suzanne M. Mead/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Ardent Crematory 2-19-2008 | Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician LUNG CANCER, METASTATIC YEARS disease or condition resulting in death) /Medical Due to ( ar a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nunsequence of) Examine the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown DIABETES Be Completed 24b. Were autopsy findings available prior to completion of cause of death? ASBESTOS EXPOSURE 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No EMPHUSEMA 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Mother (Specify) | HOSPICE 1 ☐ Yes 🌠 No Certification: To 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

6+1 State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEMARLES ST. SUITE 209 BALTIMORE, MO ZIZOH DANIEUE DOBERMAN, MO 6565

31. Date filed (Month, Day, Year) 32. Registrar's Signature

29c. License number

D64395

29d. Date signed (Month, Day, Year)

FEBRUARY 18,2008

(Check only one)

29b. Signature and title of certific

and manner stated.

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Physician 6:35 a <sup>M</sup> February 13 2008 Ethel Rebecca Mullinix /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospice Dove House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 12 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1947 1□ M 2₽F MD Director 214-46-9909 61 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at Yes 2 No Westminster MD Carroll Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21157 355 Kingsbury Way D-13 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Hygiene. Social Security Adm Claims Examiner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be ealth and Mental Rosa Lee Purdum James William Mullinix, Sr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2.
Department of Health al
Important: If item 27 is
any Injury or other trau 355 Kingsbury Way D-13 Westminster, MD Rosa Lee Mullinix/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 02/16/2008 Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial Gardens Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Fun Service Licens Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 17/10 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of the death certificate be executed Exami and burial-trai Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy Month Year Day in the past 12 mon 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknow signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has page this certificate 1∐ Yes 25. Was case referred medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specific) 10 မ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 2 Accident To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At h arm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exa The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification WJL no completed cause of death (Item 23a) (Type, Print)

4 State Name and address of person

Year)

2008

FEB

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 06465

|                                                                                                                                                                                                                                                             |                | 1- For State                                                                  | ,                                                            | tificate of L       |                                      |                                  | 7.0                                              | 2. U U                                                | 0 0040                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------|--------------------------------------|----------------------------------|--------------------------------------------------|-------------------------------------------------------|--------------------------------------------------|
| Physicia                                                                                                                                                                                                                                                    |                | Registrar  1. Decedent's Name (First, Middle,Last                             | )                                                            |                     |                                      |                                  | 2. Date of Death                                 | 1                                                     | 3. Time of Death                                 |
| edical Exami                                                                                                                                                                                                                                                |                | Kenneth Jas                                                                   | on Morris                                                    |                     |                                      |                                  | February 9                                       | , 2008                                                | 0230 hrs                                         |
|                                                                                                                                                                                                                                                             |                | 4a. Facility Name (if not institution, give                                   | street and number)                                           |                     | City, Town, or                       | r Location of D                  | eath                                             | 4c. County of Death                                   |                                                  |
|                                                                                                                                                                                                                                                             |                | Prince Georges Hospital                                                       |                                                              |                     | Cheverly                             | 1"                               |                                                  | Prince George                                         |                                                  |
| Funeral<br>Director                                                                                                                                                                                                                                         |                | 3/7 11-0200                                                                   | 7. Age (In yrs. la                                           |                     | If Under 1 Yea<br>Months Day         |                                  | Min. 11/20/                                      | (MM/DD/YYYY) 9. Birth<br>Foreig<br>1980               | nplace (State or<br>number Mashington<br>DC      |
| è                                                                                                                                                                                                                                                           |                | Usual Residence of Decedent  10a. State 10b. County                           | 10c. City.                                                   | Town or Location    | n                                    |                                  |                                                  |                                                       | 10d. Inside City Limits                          |
| ow as                                                                                                                                                                                                                                                       |                |                                                                               |                                                              |                     |                                      | _                                |                                                  |                                                       | 1 X Yes 2 No                                     |
| Maryland<br>28a-f show any<br><u>d at once.</u>                                                                                                                                                                                                             | iç             | MD Prince (                                                                   | George's                                                     | Distri              | ct <u>Heig</u><br>10f. Zip Code      | hts                              | 10                                               | g. Citizen of What Cour                               | ntry?                                            |
| re Mai<br>or 28                                                                                                                                                                                                                                             | Director       |                                                                               |                                                              |                     | 20                                   | 747                              |                                                  | II. C                                                 |                                                  |
| vith the s 23a                                                                                                                                                                                                                                              | ral            | 6332 Sunvalley T                                                              | errace 12. Was Decedent Ever in U.                           |                     | Decedent of Hi                       | spanic Origin                    | ? ( Specify Yes or No-                           |                                                       | can Indian, Black,                               |
| r death with the Maryland<br>or items 23a or 28a-f sho<br>must be notified at once.                                                                                                                                                                         | Funeral        | 1 X Never Married 2 Married                                                   | Armed Forces?  1 Yes 2 X No                                  | If Yes              | s, specify Cuba                      | n, Mexican, Po                   | uerto Rican, etc.)                               | White, etc.                                           | laan                                             |
| ifter d<br>il", or                                                                                                                                                                                                                                          |                | 3 Widowed 4 Divorced                                                          | If Yes, Give Year                                            | 1 1                 | Yes 2 X No                           | specify:                         |                                                  | Specify: Ame                                          | lcan-<br>rican                                   |
| ours a<br>atura<br>xamii                                                                                                                                                                                                                                    | d by           | 15. Decedent's Education (Specify on                                          |                                                              | 16a. Decedent's     | s Usual Occupa<br>st of working life |                                  |                                                  | 16b. Kind of Business/                                |                                                  |
| 6<br>172 h<br>an "n<br>ic I E                                                                                                                                                                                                                               | Completed      | Elementary/Secondary (0-12)                                                   | College (1-4 or 5+)                                          | damig mod           | or or working are                    | 0. 00                            | J , 5 ( ) 5 ( )                                  |                                                       |                                                  |
| within rer th                                                                                                                                                                                                                                               | Juc            | 12<br>17. Father's Name (First, Middle, Last)                                 |                                                              | Mater               | ial Spe                              | cialis                           | <b>t</b><br>Name (First, Middle, M               |                                                       | Government                                       |
| 15-<br>filed<br>al Hyg<br>ed off                                                                                                                                                                                                                            | Be C           |                                                                               | <b>:</b> _                                                   |                     |                                      |                                  |                                                  |                                                       |                                                  |
| 21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medic                                                                                                                                                                      | 0 B            | Kenneth A. Morr: 19a. Informant's Name/Relationship (T                        |                                                              | 19b. Mailing        | Address (Stre                        | et and Numbe                     | r or Rural Route Num                             | nt<br>ber, City or Town, State                        | , Zip Code)                                      |
| , MD 21215-0036 eand 2 should be filed within 72 hours after death with the Maryland eath and Montal Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranunatic event, the Medical Examiner must be notified at once              | _              | Jocelyn L. Brent                                                              | / Mother                                                     | 3103 (              | Dueens                               | Chape 1                          | Rd. #101                                         | Mount Ranie                                           | er. MD 20712                                     |
| e, P<br>1 and<br>1 and<br>Health<br>item                                                                                                                                                                                                                    |                | 20a. Method of Disposition                                                    | 20b. I                                                       | Place of Dispositi  | ion (Name of ce                      | emetery,                         | Date                                             | 20c. Location - City or                               | Town, State                                      |
| nor<br>Pages<br>ant of<br>nt: If                                                                                                                                                                                                                            |                | 1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:                          | Kemovar nom State                                            | •                   |                                      | Mom ,                            | 2/18/2008                                        | Landover.                                             | MD                                               |
| Baltimore, MD 21215-0036 Deparit. Pages 1 and 2 should be filed within 72 hours after became to 94 and 2 should be filed within 72 hours after Important: If tiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examinar. |                | 21. Signature of Funeral Service Licen                                        | see Nac                                                      | 22. Na              | ame and Addres                       | ss of Facility                   | McGuire Fu                                       | Landover,<br>neral Servi                              | ce, Inc.                                         |
| E P P E                                                                                                                                                                                                                                                     |                | Undre Johan                                                                   | ypson                                                        | 740                 | 00 Geor                              | gia Ave                          | e., N.W. W                                       | ashington,                                            | D.C. 20012                                       |
| Physician                                                                                                                                                                                                                                                   |                | 23a. Part I. Enter the disease, or comp<br>failure. List only one cause on ea | in tions that caused the death.<br>ch line.                  | . Do not enter the  | e mode of dying                      | g, such as card                  | liac or respiratory arre                         | est, shock, or heart                                  | Approximate Interval<br>Between Onset and        |
| /Medical                                                                                                                                                                                                                                                    |                |                                                                               | Multiple Gunshot Woun                                        |                     |                                      |                                  |                                                  |                                                       | Death                                            |
|                                                                                                                                                                                                                                                             |                | h                                                                             | Due to (or as a consequence o                                | f):                 |                                      |                                  |                                                  |                                                       |                                                  |
|                                                                                                                                                                                                                                                             | je je          | if any, leading to immediate                                                  | Due to (or as a consequence o                                | f):                 |                                      |                                  |                                                  |                                                       |                                                  |
|                                                                                                                                                                                                                                                             | Examiner       | Couse Enter Underlying Couse (Disease or injury that initiated C.             | Due to (or as a consequence o                                | f).                 |                                      |                                  |                                                  |                                                       | 1                                                |
| kecuted                                                                                                                                                                                                                                                     | Exa            | events resulting in death) Last d.                                            | Due to (or as a consequence o                                | 1).                 |                                      |                                  |                                                  |                                                       |                                                  |
| जिस्र ७                                                                                                                                                                                                                                                     | Medical        | UNPENDED                                                                      | AMENDED                                                      |                     |                                      |                                  |                                                  |                                                       |                                                  |
| Sox 68760,<br>death certificate be exe<br>te attending physician a<br>1 for use as the burial                                                                                                                                                               | Med            | IF FEMALE:                                                                    | 23c. If yes, outcome of preg                                 | nancy               |                                      |                                  |                                                  | 23d. Date of deliver                                  | y                                                |
| 687<br>ertific<br>ding p                                                                                                                                                                                                                                    | ian/           | 23b. Was decedent pregnant in the past 12 months?                             | 1 Live birth Pregnant at time of de                          | oth -               |                                      | Ectopic p                        | regnancy                                         | Month                                                 | Day Year                                         |
| P.O. Box 687 that the death certific ned by the attending I detached for use as the                                                                                                                                                                         | Physician/     | 1 Yes 2 No 9 Unknown                                                          |                                                              | oath 5 Oth          | er (Specify)                         |                                  |                                                  |                                                       |                                                  |
|                                                                                                                                                                                                                                                             | P              | Part II. Other significant conditions                                         | contributing to death but not re                             | esulting in the ur  | nderlying cause                      | given in Part                    | I. 23e. Did to                                   | bacco use contribute to                               | the cause of death?                              |
| - 8 20 e                                                                                                                                                                                                                                                    | d by           |                                                                               |                                                              |                     |                                      |                                  | 1 Yes                                            | 2 V No 3 Pro                                          | bably 4 Unknown                                  |
| ords,<br>w requir<br>s been s<br>should                                                                                                                                                                                                                     | ete            |                                                                               |                                                              |                     |                                      |                                  | 24a. Was a<br>autop                              |                                                       | utopsy findings available completion of cause of |
| of Vital Records, ng Physician: The law requir ther this certificate has been si meral director, page 2 should b                                                                                                                                            | Completed      |                                                                               |                                                              |                     |                                      | ···                              | perfor<br>1 ✓ Yes                                | med? death?                                           |                                                  |
| DZ01                                                                                                                                                                                                                                                        | ပိ             | 25. Was case referred to medical                                              |                                                              |                     | 26.Plac                              | ce of Death (C                   | heck only one)                                   |                                                       |                                                  |
| Vita<br>ysicia<br>his cer<br>direct                                                                                                                                                                                                                         | <b>B</b>       | examiner?<br>1 ✓ Yes 2 No                                                     | lospital: 1 Inpatient 2                                      | ER/Outpatient       | 3 DOA                                | Other 1                          | Nursing Home 5                                   | Residence 6 Othe                                      | r:                                               |
| Ivision of Vital In Attending Physician: or Attending Physician: the death.  Director: After this certifing the funeral director,                                                                                                                           | ت:<br>ح        | 27. Manner of Death                                                           | 28a. Date of Injury<br>(Month, Day, Year)<br>FOUND:          | 28b. Time of In     | jury 28c. Inj                        | jury at Work?                    | 28d. Describe t<br>Subject sho                   | now injury occurred                                   |                                                  |
| ion<br>tendii<br>eath.<br>tor: /                                                                                                                                                                                                                            | 흝              | 1 Natural 5 Pending 2 Accident Investigati                                    | F-1-0 0000                                                   | FOUND:<br>2355 hrs  | 1                                    | Yes 2 V N                        | lo Casjout Silo                                  |                                                       |                                                  |
| Division<br>tal or Attendir<br>s after death.<br>al Director:                                                                                                                                                                                               | ij             | 3 Suicide 6 Could not                                                         | be 28e. Place of Injury - At h                               | ome, farm, street   | t, factory, office                   | building, etc.                   |                                                  | Street and Number or R<br>State)<br>E, Washington, DC | ural Route Number, City                          |
| Di<br>lospital<br>f hours a<br>uneral I                                                                                                                                                                                                                     | Certification: | 4 V Homicide determined                                                       | (opean)/ Alley                                               |                     |                                      |                                  |                                                  |                                                       |                                                  |
| he Ho<br>in 24 h<br>he Fu                                                                                                                                                                                                                                   |                | 29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner       | an: To the best of my knowled :On the basis of examination a | ge, death occurrend | ed at the time, on, in my opinion    | date and place<br>on, death occu | e, and due to the caus<br>gred at the time, date | e(s) and manner as sta<br>and place, and due to t     | ted.<br>ne cause(s)                              |
| Division To the Hospital or Attendif within 24 hours after death. To the Funeral Director: /                                                                                                                                                                | Medical        | 29b. Signature and Aftle of ceptifier                                         | and manner stated.                                           |                     |                                      | nse number                       | -                                                | 29d. Date signed (Mo                                  |                                                  |
| _ <                                                                                                                                                                                                                                                         | _              | / // /                                                                        | 1 //                                                         |                     | - 1                                  | S.M.E.                           |                                                  | February 9, 200                                       |                                                  |
|                                                                                                                                                                                                                                                             |                | 30. Name and addre of pers who                                                | completed aust of death (Hern                                | 1 23a)              |                                      |                                  |                                                  |                                                       |                                                  |
| OCME                                                                                                                                                                                                                                                        |                |                                                                               | outy Chief Medical Exa                                       |                     | Penn Stree                           | et, Baltimoi                     | re, MD 21201                                     |                                                       |                                                  |
| S                                                                                                                                                                                                                                                           | tate           |                                                                               | 32 Registrar's Signat                                        | re Annual           | Es                                   |                                  |                                                  |                                                       |                                                  |
| Reais                                                                                                                                                                                                                                                       |                | FED 14 ZUU                                                                    | U RESERVED A                                                 |                     |                                      |                                  |                                                  |                                                       |                                                  |

Registrar

| 08-01481                                                                                                                                                                                                                                                                                                                                                     | -11 - 4 -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Please Type or                                                                                                                                                |                                                                                                                                                             |                  |                                           |                 |                                   | ible.                      | no neic                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------|-----------------|-----------------------------------|----------------------------|---------------------------------------------------------|
| Jason Rhea Mid                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | on State of                                                                                                                                                   | Maryland / D                                                                                                                                                |                  | nt of Health an<br>te of Death            | u mentai        |                                   |                            | 08 0646                                                 |
|                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Registrar                                                                                                                                                     |                                                                                                                                                             | Certifica        | le or Death                               |                 | Reg<br>2. Date of Death           | . No.                      | 3. Time of Death                                        |
| Physicia<br>Medical Exami                                                                                                                                                                                                                                                                                                                                    | .11.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Decedent's Name (First, Middle,Last)     Jason Rhe                                                                                                            | ea Middle                                                                                                                                                   | ton              |                                           |                 | Month [<br>February 20            | Day Year                   | 1431 hrs                                                |
| Wedical Exami                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4a. Facility Name (if not institution, give s                                                                                                                 |                                                                                                                                                             |                  | 4b. City, Town, o                         | Location of De  |                                   | 4c. County of Dea          | th                                                      |
| * CO                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4985 Columbia Road                                                                                                                                            | arect and number)                                                                                                                                           |                  | Columbia                                  |                 |                                   | Howard                     |                                                         |
| Francis                                                                                                                                                                                                                                                                                                                                                      | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Social Security Number 6. Sex                                                                                                                                 | 7. Age (In                                                                                                                                                  | yrs. last birth  | day) If Under 1 Yea                       | ar If Under 24  | Hrs. 8. Date of Birth             | (MM/DD/YYYY) 9. E          |                                                         |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                               |                                                                                                                                                             | 30               | Months Day                                |                 | Min. February                     | 24, 1977 C                 | eign<br>Country)Kentucky                                |
|                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                               | 1 2 F                                                                                                                                                       |                  | Yrs.                                      |                 | 1001001)                          | 2., 2.,                    | 7,1101100011                                            |
| any                                                                                                                                                                                                                                                                                                                                                          | H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent  10a. State 10b. County                                                                                                           | 100                                                                                                                                                         | c. City, Town o  | r Location                                |                 |                                   | <u></u>                    | 10d. Inside City Limits                                 |
| ≱ ::                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Maryland Howar                                                                                                                                                | rd                                                                                                                                                          |                  | Co                                        | lumbia          |                                   |                            | 1 Yes 2 X No                                            |
| ylanc<br>a-f sh                                                                                                                                                                                                                                                                                                                                              | 휭                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number                                                                                                                                        |                                                                                                                                                             |                  | 10f. Zip Code                             |                 | 109                               | g. Citizen of What Co      | untry?                                                  |
| P Mai e Mai or 28                                                                                                                                                                                                                                                                                                                                            | al Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4985 Columbia Road                                                                                                                                            |                                                                                                                                                             |                  |                                           | 21044           |                                   | U.S.                       | Α.                                                      |
| LL LL LL C<br>death with the Maryland<br>or items 23a or 28a-f show<br>mast be notified at once,                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                               | 12. Was Decedent Eve                                                                                                                                        | er in U.S.       | 13. Was Decedent of H                     |                 | ( Specify Yes or No-              |                            | erican Indian, Black,                                   |
| The Co ( or or items 23a must be notified)                                                                                                                                                                                                                                                                                                                   | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1 X Never Married 2 Married                                                                                                                                   | Armed Forces?                                                                                                                                               |                  | If Yes, specify Cuba                      | n, Mexican, Pu  | erto Rican, etc.)                 | White, etc.                |                                                         |
| ter de                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3 Widowed 4 Divorced If                                                                                                                                       | 1 Yes 2 X<br>Yes, Give Year                                                                                                                                 | No               | 1 Yes 2 X N                               | specify:        |                                   | Specify: C                 | aucasian                                                |
| Irs af<br>tural'                                                                                                                                                                                                                                                                                                                                             | ē                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only                                                                                                                        | or Dates:                                                                                                                                                   |                  | ecedent's Usual Occupa                    |                 |                                   | 16b. Kind of Busines       | s/Industry                                              |
| 2 hou                                                                                                                                                                                                                                                                                                                                                        | etec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Elementary/Secondary (0-12)                                                                                                                                   | College (1-4 or 5+)                                                                                                                                         | d                | uring most of working life                | e. DO NOT use   | e retired)                        |                            |                                                         |
| 936<br>thin 7<br>thar<br>thar<br>edica                                                                                                                                                                                                                                                                                                                       | ם                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                               | 2                                                                                                                                                           |                  | Cleri                                     | cal             |                                   | Accour                     | iting                                                   |
| 5-00<br>ed wi<br>lygier<br>other                                                                                                                                                                                                                                                                                                                             | Completed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 17. Father's Name (First, Middle, Last)                                                                                                                       |                                                                                                                                                             |                  |                                           | 18.Mother's N   | lame (First, Middle, M            | aiden Surname)             |                                                         |
| 215<br>be fill<br>ntal H<br>rked<br>ent, t                                                                                                                                                                                                                                                                                                                   | Be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Danny Rhea Midd                                                                                                                                               | leton                                                                                                                                                       |                  |                                           |                 | Karen Diane 1                     |                            |                                                         |
| 21<br>ould ould s man                                                                                                                                                                                                                                                                                                                                        | 의                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 19a. Informant's Name/Relationship (Typ                                                                                                                       | e, Print )                                                                                                                                                  |                  | Mailing Address (Stre                     |                 |                                   |                            |                                                         |
| MD<br>12 sh<br>th an<br>17 i                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Karen E. Middleton                                                                                                                                            | - Mother                                                                                                                                                    |                  | 5205 Chestnut                             |                 |                                   |                            |                                                         |
| re,<br>I and<br>Heal<br>Fiten                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20a. Method of Disposition  1 X Burial 2 Cremation 3                                                                                                          | Removal from State                                                                                                                                          |                  | Disposition (Name of cory or other place) | emetery,        | Date                              | 20c. Location - City       | or rown, State                                          |
| molages                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4 Donation 5 Other Specify:                                                                                                                                   | Kemovai nom State                                                                                                                                           | Restha           | ven Cemetery                              | 0               | 2/29/2008                         | Louisville                 | , Kentucky                                              |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens in a start and a should be filed with the Waturali of tiems 7 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner mast be notified at once. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 21. Signature of Funeral Service License                                                                                                                      | ee                                                                                                                                                          |                  | 22. Name and Addres                       |                 |                                   |                            |                                                         |
| in In Personal                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | The                                                                                                                                                           |                                                                                                                                                             |                  |                                           | -               | Avenue, Sil                       |                            |                                                         |
| Physician                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23a. Part I. Enter the disease, or complice failure. List only one cause on each                                                                              | ations that caused the                                                                                                                                      | death. Do not    | enter the mode of dying                   | , such as cardi | iac or respiratory arre           | st, shock, or heart        | Approximate interval<br>Between Onset and               |
| /Medical                                                                                                                                                                                                                                                                                                                                                     | _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Immediate Cause (Final disease a.                                                                                                                             | Diabetic ket                                                                                                                                                | oacidosi         | S                                         |                 |                                   |                            | Death                                                   |
| xaminer                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | or condition resulting in death)  Due to (or as a consequence of):                                                                                            |                                                                                                                                                             |                  |                                           |                 |                                   |                            |                                                         |
|                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Sequentially list conditions, b.                                                                                                                              | un to for on a conseque                                                                                                                                     | onco of):        |                                           |                 |                                   |                            | +                                                       |
|                                                                                                                                                                                                                                                                                                                                                              | ine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause                                                                   |                                                                                                                                                             |                  |                                           |                 |                                   |                            |                                                         |
| B =                                                                                                                                                                                                                                                                                                                                                          | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | sease or injury that initiated ents resulting in death) Last Due to (or as a consequence of):                                                                 |                                                                                                                                                             |                  |                                           |                 |                                   |                            |                                                         |
| executed an and al-transit                                                                                                                                                                                                                                                                                                                                   | ical E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | d                                                                                                                                                             |                                                                                                                                                             |                  |                                           |                 |                                   |                            |                                                         |
| ਤ ਜ਼ਿ                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ☐ UNPENDED                                                                                                                                                    | #Z3a,27,perM                                                                                                                                                | E,g877 3         | /12/08 T                                  |                 |                                   |                            |                                                         |
| 760<br>icate l<br>physi<br>the bu                                                                                                                                                                                                                                                                                                                            | Physician/Med                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | IF FEMALE:<br>23b. Was decedent pregnant in the                                                                                                               | 23c. If yes, outcome                                                                                                                                        | of pregnancy     |                                           | Cotonia na      |                                   | 23d. Date of deliver Month | very<br>Day Year                                        |
| 68°<br>certific<br>nding<br>se as                                                                                                                                                                                                                                                                                                                            | ian                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | past 12 months?                                                                                                                                               | 1 Live birth  Pregnant at time                                                                                                                              | e of death _     | -                                         | Ectopic pr      | egnancy                           | Month                      | Day Tour                                                |
| leath e atter                                                                                                                                                                                                                                                                                                                                                | sic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1 Yes 2 No 9 Unknown 9 Unknown                                                                                                                                |                                                                                                                                                             |                  |                                           |                 |                                   |                            |                                                         |
| O. E<br>tribe of<br>by th                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Part II. Other significant conditions                                                                                                                         | contributing to death but                                                                                                                                   | ut not resulting | in the underlying cause                   | given in Part I | . 23e. Did to                     | bacco use contribute       | to the cause of death?                                  |
| P.(<br>es tha<br>egned<br>oe det                                                                                                                                                                                                                                                                                                                             | by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                                                                                                                             |                  |                                           |                 | 1 Yes                             | 2 No 3 F                   | Probably 4 🗹 Unknown                                    |
| ds,<br>equir<br>een si<br>ould t                                                                                                                                                                                                                                                                                                                             | ompleted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                               | -                                                                                                                                                           |                  |                                           |                 | 24a. Was a<br>autops              |                            | autopsy findings available<br>to completion of cause of |
| COF<br>law r<br>has b                                                                                                                                                                                                                                                                                                                                        | ğ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                               | <del> </del>                                                                                                                                                |                  |                                           |                 | perfor                            | med? death                 | ?                                                       |
| Re<br>The<br>ficate                                                                                                                                                                                                                                                                                                                                          | With the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the stand |                                                                                                                                                               |                                                                                                                                                             |                  |                                           |                 |                                   | 2 No 1 🗸                   | res 2 No                                                |
| ital<br>ician:<br>certi                                                                                                                                                                                                                                                                                                                                      | Be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 25. Was case referred to medical examiner?                                                                                                                    | to medical 26.Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Scene   Other 4 Nursing Home 5 Residence 6 ✔ Other: Scene |                  |                                           |                 |                                   |                            |                                                         |
| fVi<br>Physi<br>erthis<br>raldii                                                                                                                                                                                                                                                                                                                             | To                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1 Yes 2 No 27. Manner of Death                                                                                                                                | 28a. Date of Injury                                                                                                                                         |                  |                                           | jury at Work?   |                                   | now injury occurred        |                                                         |
| D O ding ding h. After stune                                                                                                                                                                                                                                                                                                                                 | ou:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1 Natural 5 Pending                                                                                                                                           | (Month, Day,Year                                                                                                                                            |                  |                                           | Yes 2 No        | 0                                 |                            |                                                         |
| SiO<br>Atten<br>deat<br>deat<br>by the                                                                                                                                                                                                                                                                                                                       | cati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2 Accident Investigation                                                                                                                                      | 28e Place of Injury                                                                                                                                         | v - At home fa   | rm street factory office                  | building, etc.  | 28f, Location (S                  | Street and Number or       | Rural Route Number, City                                |
| Divi                                                                                                                                                                                                                                                                                                                                                         | 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura or Town, State) 28g. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                               |                                                                                                                                                             |                  |                                           |                 |                                   |                            |                                                         |
|                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                               |                                                                                                                                                             |                  |                                           |                 | e(s) and manner as                | stated.                    |                                                         |
| the H<br>in 24<br>he Fu<br>pletel                                                                                                                                                                                                                                                                                                                            | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                               |                                                                                                                                                             |                  |                                           |                 |                                   | o the cause(s)             |                                                         |
| To Twith with com                                                                                                                                                                                                                                                                                                                                            | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Description on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                               |                                                                                                                                                             |                  |                                           |                 | d. Date signed (Month, Day, Year) |                            |                                                         |
| Je.                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                               | W 1: +                                                                                                                                                      |                  | 0.0                                       | C.M.E.          |                                   | February 21, 2             | 2008                                                    |
|                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Werman My mont, mis                                                                                                                                           |                                                                                                                                                             |                  |                                           |                 |                                   | ·                          |                                                         |
| _                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 |                                                                                                                                                             |                  |                                           |                 |                                   |                            |                                                         |
|                                                                                                                                                                                                                                                                                                                                                              | tate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                               | 22 Majetrar's                                                                                                                                               |                  | A. a. M. a.                               |                 |                                   |                            |                                                         |
| S<br>Regis                                                                                                                                                                                                                                                                                                                                                   | tate<br>trar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 31. Date filed (Month Bay, Yaar 6 20                                                                                                                          | 08 32. Tegistrar's                                                                                                                                          | 1 15             | KARRAGE )                                 |                 |                                   |                            |                                                         |
|                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                               |                                                                                                                                                             |                  |                                           |                 |                                   |                            |                                                         |

Division or Vital Records, P.O. Box 68760, hours after death ineral Director:

Saltimore, Maryland 21215-0036

| Diabetes Perrit                                                         | is - nisurni bep.                                                                                                                                                            | 1 Yes 2 No 3 Probably 444 Unknow                                                |
|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| Coronary Artery                                                         | Disease                                                                                                                                                                      | 24a. Was an autopsy performed?  1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No                   |
| 25. Was case referred to medical examiner?                              | Li-said-li                                                                                                                                                                   | of Death (Check only one)                                                       |
| 1 ☐ Yes 2/ No                                                           | Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nur.                                                                                                          | sing Home 5 ☐ Residence 6 ☐ Other (Specify)                                     |
| 27. Manner of Death  1 ∰ Natural 5 ☐ Pending 2 ☐ Accident investigation |                                                                                                                                                                              | 28d. Describe how injury occurred                                               |
| 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine                     |                                                                                                                                                                              | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |
|                                                                         | hysician: To the best of my knowledge, death occurred at the time, date and uniner: On the basis of examination and/or investigation, in my opinion, deat and manner stated. |                                                                                 |

2008

29b. Signature and

29c. License number D16273

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Revathy Murthy MD 6130 Landover Road Cheverly, Maryland 20785

31. Date filed (Month, Day, Year) FEB 19 Registrar

Certification: To

Medical



within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 CHRISTINE Physician 6:01AM 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 72 3/21/1935 Germany 162-36-9397 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 No Director Prince George's Hyattsville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20782 U.S.A. 5615 30th Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after an and Mental Hygiene.

Is marked other than "natural", or itel 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurants Waitress 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Karolina Barton Emil Somnitz ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 | Darrel W. Mabry, Husband 5615 30th Avenue, Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If it any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/26/2008 | Arlington, VA Arlington Nat. Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 40 candia **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has bage 2 s autopsy performed 2 10 funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 10 1 Dimpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner eath 28c. Injury at Work? After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide determined 4 Homicide

P.O. Box 68760, Division or Vital Records, or Attending Physician:

ours after death.

neral Director: A
filled in by the fi To the Hospital o within 24 hours aft To the Funeral Di completely filled in

State Registrar

MARK 31. Date filed (Month, Day, Year FFR 1 9 2008 FFB 19

29a. Certifier

Medical

MAPLE 32. Registrar's Sign

MD 57/31

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB

14

32 Registrar's Signature

|                     | 1                                                                                                                                                                                                                                                                                                 | ,                | 1- State of Maryland State of Maryland                                                                                                                                                                                        | / Department of Health and N<br>Certificate of Death                                                                  | Mental Hygiei<br>Reg.                          | ZHHK Hbu /I                                                         |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------------|
| C                   | Physic<br>/Medi                                                                                                                                                                                                                                                                                   |                  | 1. Decedent's Name (First, Middle, Last)  Irene G. Ore                                                                                                                                                                        | an                                                                                                                    | 2. Date of Death Month Feb. 12                 | 3. Time of Death                                                    |
|                     | Exami                                                                                                                                                                                                                                                                                             |                  | 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospi                                                                                                                                     |                                                                                                                       |                                                | 4c. County of Death<br>Montgomery                                   |
|                     | Funeral<br>Director                                                                                                                                                                                                                                                                               |                  | 5. Social Security Number 213-63-1476 6. Sex 1                                                                                                                                                                                | rt birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.                                                 | 8. Date of Birth<br>(Month, Day, Ye<br>6/28/19 | 9. Birthplace (State or Foreign<br>Country)<br>MEXICO               |
|                     | e Maryland<br>8a-f show<br>tiffed at                                                                                                                                                                                                                                                              | ctor             | 10a. State 10b. County 10c. City,                                                                                                                                                                                             | Town or Location<br>attsville                                                                                         |                                                | 10d. Inside City Limits 1 □Yes 2 No                                 |
|                     | ath with the 23a or 24 ust be no                                                                                                                                                                                                                                                                  | Funeral Director | 10e. Street and Number 2003 Somer Set Street                                                                                                                                                                                  | 10f. Zip Code 20782                                                                                                   | -                                              | Citizen of What Country?                                            |
| 900                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. | d by Fune        | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married If Yes, Give Year or Dates:                                                         | 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  1X Yes 2□ No Specify: Mexican       |                                                | 14. Race - American Indian, Black, White, etc.  Specify: White      |
| Maryland 21215-0036 | ed within 72 h<br>giene.<br>er than "natu<br>r, the Medica                                                                                                                                                                                                                                        | Completed by     | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)                                                                                                               | Decedent's Usual Occupation     (Give kind of work done during most of work life. DO NOT use retired)     Housekeeper | ing 16b                                        | . Kind of Business/Industry  Domestic                               |
| yland               | ould be file<br>Mental Hy<br>larked oth<br>latic event                                                                                                                                                                                                                                            | To Be (          | Silverio Marquez                                                                                                                                                                                                              | Artemia                                                                                                               | e (First, Middle, Maid<br>Herrera              | à                                                                   |
|                     | 1 and 2 sh<br>Health and<br>In 27 Is m                                                                                                                                                                                                                                                            |                  | Santiago Oran/Husband                                                                                                                                                                                                         | 19b. Mailing Address (Street and Number or Run<br>2003 Somer Set St                                                   | reet Hya                                       | attsville,Md20782                                                   |
| Baltimore,          | it. Pages<br>idment of l<br>rtant: If ite<br>njury or o                                                                                                                                                                                                                                           |                  | Burial 2 □ Cremation 3 Zeroval from State Gun<br>4 □ Donation 5 □ Other (Spacify) Sat                                                                                                                                         | ada Lupe or other place)<br>ada Lupe<br>nta Ana                                                                       | /2008 I                                        | Location - City or Town, State<br>Puebla, Mexico                    |
| Ba                  | perm<br>Depa<br>Impo<br>any i                                                                                                                                                                                                                                                                     |                  | 21. Signature is Funeral Service Vicenses                                                                                                                                                                                     |                                                                                                                       | vd.Silve                                       | er Spring, Md20910                                                  |
| 100                 | Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                 |                  | 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequent | hree                                                                                                                  | or respiratory arrest,                         | Approximate<br>Interval Between<br>Onset and Death                  |
| 98760,              | ficate be executed physician and sthe burial-transit                                                                                                                                                                                                                                              | dical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last  b. Due to ibr as a consequence.  c. Due to (or as a consequence.) |                                                                                                                       |                                                |                                                                     |
| O. Box 6            | death certi<br>e attending<br>d for use a                                                                                                                                                                                                                                                         | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat                                            | eath 3 Ectopic pregnancy                                                                                              |                                                | 23d. Date of delivery<br>Month Day Year                             |
| Records, P          | law requires that the<br>as been signed by th<br>2 should be detache                                                                                                                                                                                                                              | by               | Part II. Other significant conditions contributing to death but not resulting                                                                                                                                                 | ng in the underlying cause given in Part I.                                                                           | 23e. Did tobacc                                | o use contribute to the cause of death?  2 No 3 Probably 4 Othknown |
| _                   | The                                                                                                                                                                                                                                                                                               | Completed        |                                                                                                                                                                                                                               |                                                                                                                       | 24a. Was an autopsy performed?                 |                                                                     |
| VII                 | Physician: this certific ral director,                                                                                                                                                                                                                                                            | o Be             | 25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Thospital: 2 TER                                                                                                                                          |                                                                                                                       |                                                |                                                                     |
| sion or             | nding Physician:<br>uth.<br>r: After this certific<br>e funeral director,                                                                                                                                                                                                                         | ation: To        |                                                                                                                                                                                                                               | A I Nursing Hor                                                                                                       | ne 5 ☐ Residence<br>28d. Describe how in       | 6 ☐Other (Specify)<br>jury occurred                                 |
| DIVIS               | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer                                                                                                                                                                       | Certification:   | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury · At home building, etc. (Specify)                                                                                                                               |                                                                                                                       | City or Town, Sta                              | ,                                                                   |
|                     | the Hosp<br>hin 24 hou<br>the Fune<br>apletely fil                                                                                                                                                                                                                                                | edical           | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.                                                                            | and/or investigation, in my opinion, death occurr                                                                     | and due to the cause<br>ed at the time, date a | (s) and manner as stated.<br>and place, and due to the cause(s)     |
|                     | c viti                                                                                                                                                                                                                                                                                            | Σ                | 29b. Signature and title of certifier  (As In C 5.0)                                                                                                                                                                          | 29c. License number 00064483                                                                                          | 29d. D                                         | Date signed (Month, Day, Year)                                      |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kashif Firozvi M.D. 2101 M.A. 31. Date filed (Month, Day, Year)
FEB 1 4 2008

2101 Medical Park Drive Silver Spring, Md 20902 3 Registrar's Signature

State Registrar

Brz30 lok pu. ME's opera fellunditte

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year AM Sile Α. 0 02 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salis Wicomico If Under 1 Year 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F 343-22-1018 Director 79 03-19-1928 Illinois Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f sh notified a 1 ☐ Yes 2 No Director MD Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or Items 23a or the Medical Examiner must be n 12140 Drawbridge Road 21853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Completed by 3 Widowed 4 □ Divorced ear or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 none Secretary University of MD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should to Department of Health and Ment, Important: If item 27 is marked am Injury or other traumatite even Fred Frazier Geraldine Miller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Phillips/Son 12140 Drawbridge Road, Princess Anne, MD 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 02/16/2008 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, Maryland Signature of Funeral Convice Licensee 22. Name and Address of Facility Hinman Funeral Home 3a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Princess Anne. MD 21853 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by peen has certificate funeral director, Be Certification: To I

Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: To the Hospital completely

|                                                        |                                                                                        | - 1 100 Jane 0 1 1 100 abiy 1 1 100 abiy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
|--------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
|                                                        |                                                                                        | 24a. Was an autopsy performed?  1 Yes 22 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 22 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No 25 No |  |  |
| 25. Was case referred to medical examiner?             | 26. Place of Death (C                                                                  | Check only one)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| 1 Yes 2 No                                             | Hospital: 2☐ER/Outpatient 3☐DOA Other: 4☐ Nursing Home                                 | e 5 Residence 6 Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| 27. Manner Death Natural 5 Pending Death Investigation | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 □ Yes 2 □ No             | d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| 3 ☐ Suicide 6 ☐ Could not be determined                | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| 29a. Certifier CertifyIng Phys                         | sician: To the best of my knowledge, death occurred at the time, date and place, and   | d due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

2008

Medical

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 11, **Physician** Mary Wright Pond 6:42 рм 2008 February /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Westminster Carroll Hospital Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Apr 3, 1917 9. Birthplace (State or Foreign **Funeral** 1 □ M 90 Virginia Director 216-66-1240 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location a or 28a-f show be notified at 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Maryland Carroll Westminster 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 299 Ridge Road 21157 USA "natural", or items 23a Examiner must Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be tiled within 72 hours after o Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Iter Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No by white Specify: 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Wright Mary Wiatt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
94 Ridge Road, Westminster, MD 21157 19a. Informant's Name/Relationship (Type. Print) Dr. Edward Pond, son 20a Method of Disposition 20b Place of Disposition (Name of Scattlery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 2/17/2008 Winfield, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home any 91 Willis Street, Westminster, MD 21157 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death nedicte Cause (Final **Physician** Meau Nyu/ disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the bunial-trans Due to (or as a consequence of) Physician/Medical as been signed by the attending should be detached for use as IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the pest 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? page certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P this ( 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury PM 5 Pending investigation 1 Natural 2-11-08 Fellfrom Stunding Pos 2 Accident 1 ☐ Yes 2 ☑ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At hor building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 115 City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician:

Baltimore, Maryland 21215-0036

Medical Certification: Hospital or Attending To the Hosping. Within 24 hours after death.

To the Funeral Director: After a funeral Director: After a funeral filled in by the fur This dity or Town, State)

So There Dr. Westwins with the stated.

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) JI February 12,2008 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Herbert P. Henry Rd. Manchester MD 21102 MO 2973 Mauches 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 14 2008

Registrar



### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death v 12, 2008 Month February Physician Proctor Marsenia 1446 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 1 / 1 2 / 1 9 2 1 If Under 1 Year Months Days Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1**X** M 2□ F Yrs 86 Director 212-14-5572 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Directo Maryland Prince Georges Mitchellville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a may injury or other traumatic event, the Medical Examiner must once. 16805 Queen Anne Bridge Road 20716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Armed Polices: 1 XYes 2 No If Yes, Give Year or Dates:1942-45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛛 No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesperson Walker Pontiac 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Katie Proctor Marsenia ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Maryland 19a. Informant's Name/Relationship (Type. Print) 16800 QueenAnne Bridge Rd.Mitchellville, 20716 Elizabeth Frye/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 2/22/08 Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Funeral Home PA 21. Signature of uneral Service Licensee 191 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. Part1, there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) o umon 1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Under United that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician ar Due to (or as a consequence of) Physician/Medical attending properties for use as ass IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy, certificate has rector, page 2 or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Lo this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation Injury (Month, Day Year) М 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours a er dea h To the Funeral Director completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760, Division or Vital Records, Hospital

State

Registrar

30. Name of address of pers of who completed cause of death (Item 23a) (Type, Print)

5

31. Date filed (Month, Day, Year) FEB 1

29b. Signature and title of certifier

29a. Certifier

(Check only one)

32. Redistrar's Signature lower

rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Mdnth, Day, Year)

2

State Registrar 29b. Signature and title of certifier

4

FEB 1 5 2008

Year)

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item/23a) (Type, Print) 401

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician /Medical Annie Elizabeth Pinknev 9, 2008 4c. County of Death February 19:48 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Cheverly Prince Georges Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Days 1□м 🏖 F 578-46-5793 Washington, D.C. 74 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the M-dical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Capitol Heights 10e. Street and Number 10g. Citizen of What Country? Of. Zip Code 1408 Brooke Road by Funeral 20743 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3√□Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Housekeeping Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph F. Ford ဥ Ruth R. Harper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 62nd Place #b Seat\_Pleasant, Maryland 20743 Doris E. Fletcher / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/16/2008 Landover, Maryland Harmony Memorial 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 18100111 Charles E. you. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Fatal Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any leads to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed <u>Diabetes Mellitus</u> and as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐ Yes 2√□ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4√Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🍇 No 1 🔲 Inpatient ပ 2X ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 🕇 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tio of certifier 58957 2-11-08 Drive Cheverly MD 20785 30 Name and address of person who completed cause of death (Item 23

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

FEB 19

Year)

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|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------|--------------------------------|--------------------------|-------------------------------------------|---------------------------------------------|-------------------------------------------|----------------------|------------------------------|---------------------------------|
| -                              | Dhusis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | , i            | 1. Decedent's Name (First, Middle,                                             | Last)                          |                          |                                           |                                             | 2. Date of D                              | Death                |                              | 3. Time of Death                |
|                                | Physic<br>/Medi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | Patsy Ann                                                                      | Perry                          |                          |                                           |                                             | Month 2                                   | /12/2008             | Year                         | 9:50 P M                        |
|                                | Exami                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | 4a. Facility Name (If not institution,                                         | give street and number         | r)                       | 4b. City, Tov                             | vn, or Location of De                       |                                           |                      | ty of Death                  | 7,50 2                          |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 4204 Edmonston                                                                 | Rd.                            |                          | B1ade                                     | nsburg                                      |                                           | Prin                 | ce Geo                       | orge's                          |
|                                | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                |                                                                                | 6. Sex 7. A<br>1 ☐ M 2 😾 F     | age (In yrs. last birthd | Months Da                                 | ear If Under 24 h<br>ays Hours M            | lin. 8. Date of E                         | Birth<br>Dav. Year)  |                              | lace (State or Foreign<br>try)  |
| art.                           | Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | -              | Usual Residence of Decedent                                                    |                                | 71 Yrs                   |                                           |                                             | 3/18/                                     |                      |                              | ngton, D.C                      |
|                                | and w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | 10a. State 10b. County                                                         |                                | 10c. City, Town or       | Location                                  |                                             |                                           |                      | 10                           | 0d. Inside City Limits          |
|                                | Maryl<br>f sho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ō              | MD Prince                                                                      | Carnal                         |                          |                                           |                                             |                                           |                      | 1                            | 1 ☑Yes 2 ☐ No                   |
|                                | the 28a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Director       | 10e. Street and Number                                                         | George's                       | Bladens                  | 10f. Zip Co                               | de                                          |                                           | 10g. Citizen of      | What Coun                    | tn/2                            |
|                                | 3a ol                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | 4204 Edmonston                                                                 | RA                             |                          |                                           | 20710                                       |                                           |                      |                              | пу:                             |
|                                | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Items 23a or 28a-f show<br>he Medical Examiner must be notifited at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Funeral        | 11. Marital Status                                                             | 12. Was Deceden                | t Ever in U.S. 1         | 3. Was Decedent                           | of Hispanic Origin?<br>Cuban, Mexican, Pu   | (Specify Yes or N                         | U.S.A                | A •<br>ace - America         | an Indian,                      |
| 9                              | after<br>or ite                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 1 ☐ Never Married 2 ☐ Marrie                                                   |                                | ?<br>] No                |                                           |                                             | ièrto Rican, etc.)                        | Bla                  | ack, White, e                | etc.                            |
| 03                             | ral",                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | by             | 3 ☑ Widowed 4 ☐ Divorced                                                       | If Yes, Give<br>Year or Dates: | :                        | 1∟Yes 2KM                                 | No Specify:                                 |                                           | Speci                | <sup>ify:</sup> Whi          | te                              |
| 5-0                            | 72 h<br>'natu<br>dical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Completed      | 15. Decedent's (Specify only highest                                           | Education<br>grade completed)  | 16a. De                  | cedent's Usual Or                         | ccupation                                   | vorkina                                   | 16b. Kind of E       | 3usiness/Ind                 | lustry                          |
| 21                             | rithin<br>ne.<br>nan '                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | du             | Elementary/Secondary (0-12)                                                    | College (1-4or                 | 5+)                      | . DO NOT use re                           | one during most of etired)                  | TOTALING                                  |                      |                              |                                 |
| 2                              | led w<br>lygiel<br>her tl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | S              | 8                                                                              |                                | Hom                      | emaker                                    |                                             |                                           | Own Ho               |                              |                                 |
| Ind                            | be finated Harameter in the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second se | Be             | 17. Father's Name (First, Middle, L                                            | ŕ                              |                          |                                           | 18. Mother's N                              | lame (First, Middl                        | e, Maiden Surna      | me)                          |                                 |
| <u>\S</u>                      | ould<br>Mer<br>narke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ပ              | Richard E. Wind                                                                |                                |                          |                                           |                                             | V. Hutch                                  |                      |                              |                                 |
| Vai                            | s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I health and Mental Hygiene item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | 19a. Informant's Name/Relationshi                                              |                                |                          |                                           | reet and Number or                          |                                           |                      | ı, State, Zip                | Code)                           |
| e,                             | ss 1 and 2<br>of Health<br>item 27 I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | Rose M. Gauzza,                                                                | Daughter                       |                          |                                           | Dr., Edge                                   |                                           |                      |                              |                                 |
| jor                            | 0 ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation                            | 3 ☐Removal from State          | 20b. Place of Dis        | position (Name o<br>rematory or other     | place)                                      | Date                                      | 20c. Location        | - City or Tov                | wn, State                       |
| ţi                             | t. Pag<br>tment<br>tant: It                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1              | 4 Donation 5 Dother (Spe                                                       |                                | Ft. Lin                  |                                           | etery 2/                                    | 18/2008                                   | Brentwo              | ood, M                       | ID                              |
| Baltimore, Maryland 21215-0036 | permit. Pag<br>Department<br>Important: I<br>any Injury o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | H              | 21. Signature of Funeral Service L                                             | censee                         |                          | 22. Name and Ad<br>Sasch s                | ddress of Facility<br>Funeral H             | ome, P.A                                  |                      |                              | imore Avenu<br>le, MD 2078      |
| 6                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 23a. Part1. Enter the disease, or c<br>shock, or heart failure. List o         | omplications that cause        |                          |                                           |                                             |                                           |                      |                              | Approximate<br>Interval Between |
| . 1                            | Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | Immediate Cause (Final disease or condition                                    |                                | Myocardia:               |                                           |                                             |                                           |                      |                              | Onset and Death                 |
| 79                             | /Medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | resulting in death)                                                            | -                              | s a consequence of):     | LIIIIaic                                  | LIOII                                       |                                           |                      |                              |                                 |
| Н                              | Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | Commendation link committee or                                                 |                                | ension                   |                                           |                                             |                                           |                      |                              |                                 |
|                                | - ±                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ner            | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury | Due to (or dr                  | s a consequence of):     |                                           |                                             |                                           |                      |                              |                                 |
|                                | ecute<br>nd<br>trans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Examiner       | triat initiated events                                                         | ·                              | ipidemia                 |                                           |                                             |                                           |                      |                              |                                 |
| 90,                            | e exe<br>ian a<br>urial-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Ĕ              | resulting in death) Last                                                       | · ·                            | s a consequence of):     |                                           |                                             |                                           |                      |                              |                                 |
| 68760,                         | eath certificate be executed<br>attending physician and<br>for use as the burial-transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | dical          |                                                                                | d. Type 2                      | Diabetes                 | Mellitus                                  | 5                                           |                                           |                      |                              |                                 |
| Box (                          | certif<br>nding<br>ise as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Physician/Mec  | IF FEMALE:                                                                     | 23c. If yes, outcome           | e pf pregnancy           |                                           |                                             |                                           | 201.0                |                              |                                 |
| ğ                              | death<br>e atten<br>d for u                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ciar           | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No               | 1 ☐Live birth                  | 2 Fetal death            | B □Ectopic pregna                         |                                             |                                           |                      | ate of deliver<br>onth [     | y<br>Day Year                   |
| P.O.                           | the crysthe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ysi            | 9 ☐ Unknown                                                                    | 9□Unknown                      |                          |                                           | /                                           |                                           |                      |                              |                                 |
|                                | w requires that the d<br>been signed by the<br>should be detached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | Part II. Other significant condition                                           | s contributing to death I      | out not resulting in the | underlying cause                          | given in Part I.                            | 23e. Did                                  | tobacco use con      | tribute to the               | e cause of death?               |
| rds                            | quire;<br>n sign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | d by           | Irritable Bowel                                                                | Syndrome,                      | Anxiety Di               | sorder,                                   |                                             | 1 🗆                                       | Yes 2 No             | 3 Proba                      | ıbiy 4⊠Unknown                  |
| 00                             | law rec<br>as bee<br>2 shou                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | lete           | Gastroesophigal                                                                | Reflux Dic                     | 9359                     |                                           |                                             | 24a. Was                                  | an 24h               | Wore auton                   | sy findings available           |
| Re                             | е <u>т</u> е                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Completed      |                                                                                | ROTTON DIS                     | case                     |                                           |                                             | - l auto                                  | ppsy<br>ormed?       | prior to com<br>death?       | pletion of cause of             |
| tal                            | ician: Th<br>certificate<br>ector, pag                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                | 25. Was case referred to medical                                               |                                |                          |                                           | 00 51 (5                                    | 1□ Yes                                    |                      | 1 ☐ Yes 2                    | 2 □ No                          |
| >                              | Physician:<br>r this certificanal director,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | To Be          | examiner?<br>1 ☐ Yes 2 🔀 No                                                    | Hospital: 1 □ Inpati           | ent 2 ☐ ER/Outpati       | ent 3 DOA                                 |                                             | eath (Check only                          |                      |                              |                                 |
| ō                              | ding Physician:  ). After this certific funeral director,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | 27. Manner of Death                                                            | 28a. Date of Inju              | ury 28b. Time            | of 28c. l                                 | Other: 4 Nursing                            | 28d. Describe                             | how injury occur     | ner (Specify)<br>rred        | )                               |
| io                             | Attending Property of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of | 텵              | 1 X Natural 5 ☐ Pending<br>2 ☐ Accident investigat                             | (Month, Da                     | ay Year)   Injury        |                                           | Work?<br>I∐Yes 2∐No                         |                                           | ,,                   |                              |                                 |
| Division or Vital Records,     | I or Attend<br>after death<br>Director; /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Certification: | 3 Suicide 6 Could no determine                                                 | ad 28e. Place of In            | ury - At home, farm,     | street, factory, offi                     | ce                                          | 28f. Location                             | Street and Numb      | ber or Rural                 | Route Number,                   |
|                                | al or<br>s afte                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Sert           | 4 Difficine                                                                    | building, e                    | tc. (Specify)            |                                           |                                             | City or To                                | iwn, State)          |                              | ,                               |
|                                | To the Hospital or Atten within 24 hours after death To the Funeral Director: completely filled in by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Medical (      | 29a. Certifier 1 Certifying (Check only one)                                   | Physician: To the best         | of examination and/or    | ath occurred at th<br>investigation, in n | e time, date and pla<br>ny opinion, death o | ice, and due to the<br>curred at the time | cause(s) and m       | anner as sta<br>, and due to | ited.<br>the cause(s)           |
|                                | ro the vithin of the comple                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Mec            | 29b. Signature and title of certifier                                          | and manner st                  | ateu.                    |                                           | ense number                                 |                                           | 29d. Date signe      |                              |                                 |
|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                |                                                                                | MI MS                          |                          |                                           | DESEED                                      |                                           |                      |                              |                                 |
|                                | (5)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                | 30. Name and address of person wh                                              |                                |                          |                                           | D55559                                      |                                           | Februar              | у 15,                        | 2008                            |
| C/                             | _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | Thomas E. Masle                                                                |                                | Greenway                 | · · ·                                     | r Cross                                     | hel+ MT                                   | 20770                |                              |                                 |
|                                | Sta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ite            | 31. Date filed (Month, Day, Year)                                              | 32. Regist                     | rar's Signature          | Sentel L                                  | ,, Greer                                    | metr' MI                                  | 20//0                |                              |                                 |
|                                | Registr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | FEB 1 9 2008                                                                   | Elecu D                        | rar's Signa dre          |                                           |                                             |                                           |                      |                              |                                 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Fred Payne February 16, 2008 /Medical 7:15 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Leonardtown St. Mary's St. Mary's Hospital
5. Social Security Number 6. 8. Date of Birth (Month, Day, Year)
July 17, 1971 6. Sev 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2 □ F Days Hours Min Maryland Director 36 214-76-5494 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Maryland Director St. Mary's 1 ☐ Yes 2 No Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25975 Prospect Hill Road "natural", or items 23a 20659 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 K Yes 2 No 1989— If Yes, Give Year or Dates: 93 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No 9 Specify 3 Widowed 4 Divorced 93 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Verizon Technician Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental Fred F. Payne Laura Α. Maddle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 Is
any Injury or other trau Patty Payne / Wife 25975 Prospect Hill Road Mechanicsville, Maryland 20659 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 02/28/2008 5 Other (Specify) 4 □ Donation Maryland Vet. Cemetery Cheltenham, Maryland 21. Signatur by uneral Service Licens 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** advanced /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to forces a consequence off The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) led by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 KNUnknown 24b. Were autopsy findings available prior to completion of cause of death?

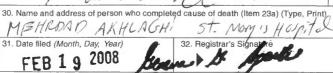
1 □ Yes 2 □ No 24a. Was an funeral director, page 2 autonsy certificate perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending XX Natural 5 ☐ Pending investigation Injury To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifiet 29c. License number 29d. Date signed (Month, Day, Year) 0060973 02/16/2008

State

Anthony PAYNE

31. Date filed (Month, Day, Year) 2008



Registrar

25500 point bookent Leanardtown

|            |                                                                                                                                                                      |                  | State of Maryland / Dep                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | lental Hygi                             | ene                           | 00170                                          |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------|-------------------------------|------------------------------------------------|
|            |                                                                                                                                                                      |                  | Registrar  1. Decedent's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | rtificate of Death                                                             |                                         | g. Noc. UUÖ                   | 004/9                                          |
| 3          | Physici                                                                                                                                                              |                  | Raymond Irvin PITCOCK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | 2. Date of Death                        | Pay / Year                    | 3. Time of Death                               |
|            | /Medic<br>Examin                                                                                                                                                     |                  | 4a. Facility Name (If not institution, give street and number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4b. City, Town, or Location of Death                                           |                                         | 4c. County of Deat            |                                                |
| 100        | Resident Control                                                                                                                                                     |                  | Washington County Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Hagerstown                                                                     |                                         | Washingt                      | on                                             |
| П          | Funeral<br>Director                                                                                                                                                  |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Months Days Hours Min.                                                         | 8. Date of Birth (Month, Day,           | Year) 9. Birt                 | hplace (State or Foreign untry)                |
| Н          | A. An An                                                                                                                                                             | Ŋ.               | 230-24-0520 81  Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | July 19                                 | 1926   Vir                    | ginia                                          |
|            | arylan<br>show<br>d at                                                                                                                                               | _                | 10a. State 10b. County 10c. City, Town or L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ocation                                                                        |                                         |                               | 10d. Inside City Limits                        |
|            | the Ma<br>28a-f                                                                                                                                                      | ecto             | Maryland Washington Hager                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | stown                                                                          |                                         |                               | 1X1Yes 2 □ No                                  |
|            | a or                                                                                                                                                                 | Ö                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10f. Zip Code                                                                  | 10(                                     | g. Citizen of What Co         | untry?                                         |
|            | death                                                                                                                                                                | Funeral Director | 1684 Langley Drive, Apt. 104           11. Marital Status         12. Was Decedent Ever in U.S.         13.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Was Decedent of Hispanic Origin? (Sp<br>If Yes, specify Cuban, Mexican, Puerto | ecify Yes or No-                        | USA<br>14. Race - Ame         |                                                |
| 36         | filed within 72 hours after death with the Maryland<br>Hygiene.<br>vther than "natural", or items 23a or 28a-f show<br>ont, the Medical Examiner must be notified at |                  | 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1 ☐ Yes 2 No Specify:                                                          | Hican, etc.)                            | Black, White                  | e, etc.                                        |
| 5-0036     | hours<br>tural?                                                                                                                                                      | ed by            | 3 ☐ Widowed 4 ☐ Divorced   Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | edent's Usual Occupation                                                       | 1                                       |                               | hite                                           |
| 215        | hin 72<br>e.<br>an "na<br>Medic                                                                                                                                      | Completed        | (Specify only highest grade completed) (Giv. life.  Elementary/Secondary (0-12) College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | e kind of work done during most of work<br>DO NOT use retired)                 | ing                                     | DD. KING OF BUSINESS/         | maastry                                        |
| 212        | ed witl                                                                                                                                                              | Som              | 9 0 Sup                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ervisor                                                                        | A                                       | ircraft M                     | g.                                             |
| and        | be do do do eve                                                                                                                                                      | Be               | 17. Father's Name (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 18. Mother's Name                                                              | e (First, Middle, Ma                    | aiden Surname)                |                                                |
| Maryland   | should be filed vind Mental Hygies marked other tumatic event, th                                                                                                    | 은                | Richard Pitcock  19a. Informant's Name/Relationship (Type. Print)  19b. Mail                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | mg Address (Street and Number or Rur.                                          |                                         | Other Tarres Other            | Zin On to                                      |
| _          | ~ (C) (c) =                                                                                                                                                          | П                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Langley Drive, Ap                                                              |                                         |                               |                                                |
| Baitimore, | ages 1 and 2<br>nt of Health<br>or other tra                                                                                                                         |                  | 20a. Method of Disposition 20b. Place of Disp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | osition (Name of Interplace)                                                   | Date 20                                 | oc. Location - City or        | Town, State                                    |
| Ĕ          | Pages<br>ment of<br>ant: If Its<br>jury or o                                                                                                                         |                  | Xibulia 2   Clemator 3   Hemoval from State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | stine Mem. Park 2/                                                             | 22/08 S                                 | t. Augusti                    | ine, Florida                                   |
| ga         | permit. Pag<br>Department<br>Important: I<br>any Injury o<br>once.                                                                                                   |                  | 21. Signature of Funeral Service Licensee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Name and Address of Facility                                                   | linnich F                               | uneral Hom                    | ne                                             |
|            |                                                                                                                                                                      |                  | 23a, Part1. Enter the disease or complications that caused the death. Do not en                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 15 E. Wilson Blvd.                                                             |                                         |                               | 21740<br>Approximate                           |
|            | Physician                                                                                                                                                            |                  | snock, or neart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |                                         |                               | Interval Between<br>Onset and Death            |
|            | /Medical                                                                                                                                                             |                  | disease or condition resulting in death)  a. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | BSTRUCTIVE LYN                                                                 | 7 7/50                                  | MIC                           | DO GRAPES                                      |
|            | Examiner                                                                                                                                                             |                  | Sequentially list conditions, b. SRUNCITI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ecrasis                                                                        |                                         |                               | 30 years                                       |
|            | nsit                                                                                                                                                                 | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                         |                               |                                                |
| 'n         | execu<br>in and<br>rial-tra                                                                                                                                          |                  | that initiated events c.  resulting in death) Last  Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                         | - 4                           | -                                              |
| ۵/۵<br>م   | cate be executed physician and the burial-transit                                                                                                                    | dical            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                         |                               |                                                |
| õ<br>X     |                                                                                                                                                                      | Q) 1             | IF FEMALE:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |                                         |                               |                                                |
| 0          | death certifi<br>e attending<br>d for use as                                                                                                                         | Physician/M      | in the past 12 months?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ⊒Ectopic pregnancy<br>□ Other <i>(specify)</i>                                 |                                         | 23d. Date of deli<br>Month    | very<br>Day Year                               |
| į          | t the d<br>by the<br>ached                                                                                                                                           | hysi             | 1 Yes 2 No 4 Pregnant at time of death 51 9 Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                         |                               |                                                |
| 'n         | The law requires that the ate has been signed by the bage 2 should be detache                                                                                        | by P             | Part II. Other significant conditions contributing to death but not resulting in the u                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Λ. · · · · · · · · · · · · · · · · · · ·                                       | 23e. Did toba                           | cco use contribute to         | the cause of death?                            |
| coras,     | requir<br>een si<br>nould                                                                                                                                            | ted              | COKONARY MELERY!                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | VISEASE                                                                        | 1 ☐ Yes                                 | 2No 3□Pro                     | obably 4 □Unknown                              |
| ב<br>ב     | has b                                                                                                                                                                | Completed        | · /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | 24a. Was an autopsy                     | prior to c                    | topsy findings available ompletion of cause of |
|            | sician: Th<br>certificate<br>rector, pag                                                                                                                             |                  | 25. Was case referred to medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | perform<br>1 Yes 2                      | death?<br>No 1 ☐ Yes          | 2No                                            |
| >          | ysicia<br>is cert<br>direct                                                                                                                                          | o Be             | examiner?  1  Yes 2 No Hospital: Inpatient 2 ER/Outpatie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 26. Place of Death                                                             |                                         | ce 6 □Other (Spec             |                                                |
| 5          | ng Ph<br>Ifter th<br>Ineral                                                                                                                                          | ü                | 27. Manner of teath 28a. Bate of Injury 28b. Time of Month, Day Year Injury 1 Injury 28b. Time of Month, Day Year Injury 1 Injury 28b. Time of Month, Day Year Injury 28b. Time of Month, Day Year Injury 28b. Time of Month, Day Year Injury 28b. Time of Month (Month, Day Year) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Month (Month) 28b. Time of Mo |                                                                                | 28d. Describe how                       |                               | ny)                                            |
| 2015       | ttendi<br>death.<br>:tor: A<br>:the fu                                                                                                                               | cati             | 2 ☐ Accident Investigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | M 1 ☐ Yes 2 ☐ No                                                               |                                         |                               |                                                |
| 2          | after d<br>Direc                                                                                                                                                     | Certification:   | 4 Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | еет, тастогу, опісе                                                            | 28f. Location (Strei<br>City or Town, 1 | et and Number or Ru<br>State) | ral Route Number,                              |
|            |                                                                                                                                                                      |                  | 29a. Certifier (Check only   Medical Examiner: On the basis of examination and/or in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | h occurred at the time, date and place,                                        | and due to the cau                      | se(s) and manner as           | stated.                                        |
|            | the H<br>in 24<br>the Fi                                                                                                                                             | edical           | one) and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | ed at the time, date                    | e and place, and due          | to the cause(s)                                |
|            | 1                                                                                                                                                                    | Σ                | 29b. Signature and title of certifier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 29c. License number                                                            | 290                                     | . Date signed (Month          | , Day, Year)                                   |
| 0          | 10                                                                                                                                                                   |                  | 30. Name and address of person who completed cause of death (Item 23a) (Type,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Print)                                                                         |                                         | -112/08                       |                                                |
|            |                                                                                                                                                                      | 1                | Wohn P. Leep 22911 J                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | effusor RLVD                                                                   | Son ITHI                                | fur m                         | 21753                                          |
|            | Stat                                                                                                                                                                 |                  | 31. Date filed (Month, Day, Year) 32. Polistrar's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Locall &                                                                       |                                         |                               |                                                |
|            | Registra                                                                                                                                                             |                  | I LU I J LUUU   A MANAGE AS A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                         |                               |                                                |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Pay 12, 2008 **Physician** James Webster Pritchett Jr. 7:00 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 23 Lerner Court Nottingham If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day Ye July 30, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 1948 Days 1 X M 2 □ F Maryland 218-50-1518 59 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show Examiner must be notified at MD Baltimore Nottingham 1 TXYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23 Lerner Court 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No white þ Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) mechanic automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be I and 2 should be fi lealth and Mental F James W. Pritchett Eula Jones ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau Crystal D. Liberto daughter 23 Lerner Court, Nottingham, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 2/15/08 Cambridge, MD 21. Signatur #Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OCANS! /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BRILLATION 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl o Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: Director: in 24 hours the Funeral Dire To the

> 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 BELANN RG BALTO-MOZIZ GAMI SEX 5066 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State **FEB 19** 2008 Registrar

and manner stated.

29a, Certifier

29b. Signature and title of certifier

cal

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                           |                   | 1 - For State of Maryland / Departr                                                                                                                                                                   | ment of H                                       |                                                          |                                                 | ene<br>. No. 2008                | 06482                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------|-------------------------------------------------|----------------------------------|----------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Physic<br>/Medi                                                                                                                                                                                           |                   | - NIIVIAV 11113 I 1310                                                                                                                                                                                |                                                 |                                                          | O Data of Double                                | 3 <sup>Day</sup> 2008            | 3. Time of Death                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Exami                                                                                                                                                                                                     |                   | 4a. Facility Name (If not institution, give street and number)  12024 Ocean Gateway Lot #9                                                                                                            | Ocean C                                         | Location of Death                                        |                                                 | 4c. County of Death              | 1                                                  |
| H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Funeral<br>Director                                                                                                                                                                                       |                   |                                                                                                                                                                                                       | f Under 1 Year<br>lonths Days                   | If Under 24 Hrs.<br>Hours Min.                           | 8. Date of Birth<br>(Month, Day, Y<br>1/7/1928  | ear) 9. Birth                    | nplace (State or Foreign<br>untry)<br>MD           |
| .0036<br>hours after death with the Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | a or 28a-f show<br>be notified at                                                                                                                                                                         | Director          | 10a. State 10b. County 10c. City, Town or Location                                                                                                                                                    |                                                 |                                                          |                                                 |                                  | 10d. Inside City Limits 1 ☐ Yes 2X No              |
| eath with th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | s 23a or 2<br>nust be no                                                                                                                                                                                  |                   |                                                                                                                                                                                                       | 10f. Zip Code<br>21842                          |                                                          | (                                               | . Citizen of What Cou<br>JSA     |                                                    |
| U36<br>urs after de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | al", or item<br>Examiner r                                                                                                                                                                                | by Funeral        | 3 ☐ Widowed 4 ☑ Divorced If Yes, Give 1 ☐ 1                                                                                                                                                           | S Decedent of Hises, specify Cuba<br>Yes 2 X No | spanic Origin? (Spe<br>in, Mexican, Puerto I<br>Specify: | cify Yes or No-<br>Rican, etc.)                 | 14. Race - Amer<br>Black, White  |                                                    |
| 1215-0036<br>within 72 hours af                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ntal Hygiene.<br>Ind other than "natural", or items 23a<br>event, the Medical Examiner must b                                                                                                             | Completed         | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)                                                                                      | d of work done d<br>NOT use retired,            | ation<br><i>Juring most of workir</i><br>)               | ng                                              | b. Kind of Business/li           |                                                    |
| land 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                           | To Be Co          | 17. Father's Name (First, Middle, Last)                                                                                                                                                               |                                                 | 18. Mother's Name                                        |                                                 | ,                                | on                                                 |
| and and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | if of Health and Mental<br>If item 27 is marked or<br>or other traumatic ev                                                                                                                               |                   | 19a. Informant's Name/Relationship (Type. Print)  Horace Davis Quillin, Jr./son  8217 SR                                                                                                              |                                                 |                                                          | l Route Number, C                               | ity or Town, State, Z            | ip Code)                                           |
| E -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Department of He Important; If iten any Injury or oth once.                                                                                                                                               |                   | 20a. Method of Disposition  1                                                                                                                                                                         | pen Cre                                         | m. 2/14                                                  |                                                 | c. Location - City or Trankford, |                                                    |
| <b>Da</b><br>permi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Depar<br>Impor<br>any Ir                                                                                                                                                                                  | o o               | 1 . 12 / / / / /                                                                                                                                                                                      | ame and Address                                 | iam St.,                                                 | Berlin, M                                       | Funeral<br>1D 21811              |                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ysician<br>Medical                                                                                                                                                                                        |                   | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):                                         | e mode of dying                                 | g, such as cardiac o                                     | respiratory arrest,                             | 5                                | Approximate Interval Between Onset and Death       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | kaminer                                                                                                                                                                                                   | iner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events c.                                                                  |                                                 |                                                          |                                                 |                                  |                                                    |
| o / oU,<br>ate be executed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | physician and<br>the burial-transit                                                                                                                                                                       | al Examine        | that initiated events resulting in death) Last  C                                                                                                                                                     |                                                 |                                                          |                                                 |                                  |                                                    |
| .C. DOX 00.<br>the death certificate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the | Physician/Medical |                                                                                                                                                                                                       | opic pregnancy<br>ner (specify)                 |                                                          |                                                 | 23d. Date of deliv               | rery<br>Day Year                                   |
| equires that                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | en signed bould be deta                                                                                                                                                                                   | ted by PI         | Part II. Other significant conditions contributing to death but not resulting in the underly                                                                                                          | ying cause give                                 | n in Part I.                                             | 23e. Did tobace                                 | co use contribute to             | the cause of death?                                |
| The law                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ficate has be<br>r, page 2 sh                                                                                                                                                                             | Completed         |                                                                                                                                                                                                       |                                                 |                                                          | 24a. Was an<br>autopsy<br>performed<br>1□ Yes 2 | prior to co                      | opsy findings available ompletion of cause of 2 No |
| ysicial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | iis certii<br>directo                                                                                                                                                                                     | To Be             | 25. Was case referred to medical examiner?  1 ★ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3                                                                                                      | 0.11                                            | 26. Place of Death                                       |                                                 | e 6 □Other (Speci                | 60                                                 |
| Attending Ph                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | r death.<br>ector: After th<br>by the funeral                                                                                                                                                             | Certification: 1  | 27. Manner of Death  1 Matural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury N  28b. Time of Injury N  28e. Place of injury - At home, farm, street, fa |                                                 | at 2<br>?<br>′es 2 □ No                                  | 8d. Describe how i                              |                                  |                                                    |
| fospital or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4 hours afte -uneral Dir ely filled in                                                                                                                                                                    | cal Cert          | 4 ☐ Homicide building, etc. (Specify)  29a. Certifier (Check only one)  2 Medical Examiner: On the basis of texamination and/or investig                                                              | curred at the time                              | e, date and place, a                                     | City or Town, So                                | o(a) and manner as a             | stated.                                            |
| To the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | within 2.  To the I complet                                                                                                                                                                               | Medical           | one) and manner stated.  29b. Signature and title of certifier                                                                                                                                        | 29c. License                                    |                                                          |                                                 | Date signed (Month,              |                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                           |                   | 30. Name and address of person who completed cause of death (item 23a) (Type, Print)                                                                                                                  | 206                                             | 241                                                      |                                                 | 2-14-08                          | ,                                                  |
| BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                           |                   | 30. Name and address of person who completed cause of death (item 23a) (Type, Print)  DOPOTHY  C. HOLZIN OZTH, M. D.  31. Date filed (Month, Day, Year)  32. Registrar's Signature                    | 203 Si                                          | NOIN ST.                                                 | SNOW H                                          | LE, MD.                          | 21863                                              |
| The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | Sta<br>Registra                                                                                                                                                                                           |                   | FEB 1 9 2008                                                                                                                                                                                          | alle)                                           |                                                          |                                                 |                                  |                                                    |

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|             |                                                                                                                                                                                                                                                     |                | For<br>State<br>Registrar                                                            |                                          | State of N                                                  | Marylan                    |                                | rtment of l                                        |                                | and Men                           |                                                | jiene<br>eg. No. 2 ()            | 08                       | 06483                                                     |
|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------|----------------------------|--------------------------------|----------------------------------------------------|--------------------------------|-----------------------------------|------------------------------------------------|----------------------------------|--------------------------|-----------------------------------------------------------|
|             |                                                                                                                                                                                                                                                     |                | Decedent's Name                                                                      | (First, Middle, La                       | st)                                                         |                            |                                |                                                    |                                |                                   | Date of Deat                                   |                                  |                          | 3. Time of Death                                          |
| 9           | Physici<br>/Medi                                                                                                                                                                                                                                    |                | Florence                                                                             | Κ.                                       | Quartey                                                     |                            |                                |                                                    |                                |                                   | Month<br>bruar                                 | y 12,                            | Year 2008                | 8:15 A <sup>M</sup>                                       |
|             | Examir                                                                                                                                                                                                                                              |                | 4a. Facility Name (If                                                                | not institution, giv                     | e street and number                                         | er)                        |                                | 4b. City, Town, o                                  | or Location of                 |                                   |                                                | 4c. County                       | y of Death               |                                                           |
|             |                                                                                                                                                                                                                                                     | 45             | 16134 Ede                                                                            |                                          |                                                             |                            |                                | Bowie                                              |                                |                                   |                                                | Princ                            | e Ge                     | orge's                                                    |
|             | Funeral<br>Director                                                                                                                                                                                                                                 |                | 5. Social Security Nu<br>218-19-80                                                   | 173                                      | I M OFF                                                     | Age (In yrs. i<br>83       | ast birthday)<br>Yrs.          | If Under 1 Year<br>Months Days                     | If Under 2<br>Hours            | 24 Hrs. 8. D<br>Min. Ju           | nate of Birth<br>Mo <i>nth, D</i> ay,<br>ne 24 | , Year)<br>1924                  | 9. Birth<br>Cou<br>Gha   |                                                           |
|             | and                                                                                                                                                                                                                                                 |                | Usual Residence of I                                                                 | Decedent<br>10b. County                  |                                                             | 10c. City                  | , Town or Lo                   | cation                                             |                                |                                   |                                                |                                  |                          | 10d. Inside City Limits                                   |
|             | Maryl<br>f sho<br>led a                                                                                                                                                                                                                             | ō              |                                                                                      | Prince (                                 | Corgote                                                     | Bow                        |                                |                                                    |                                |                                   |                                                |                                  |                          | 1 ☐ Yes 2 📆 No                                            |
|             | the 28a-                                                                                                                                                                                                                                            | Director       | 10e. Street and Num                                                                  |                                          | eorge s                                                     | DOW                        | 16                             | 10f. Zip Code                                      |                                |                                   | 1                                              | 0g. Citizen of                   | What Cou                 |                                                           |
|             | h with                                                                                                                                                                                                                                              |                | 16134 Ede                                                                            | nwood Dr                                 | ive                                                         |                            |                                | 2071                                               | .6                             |                                   |                                                | USA/Gh                           |                          |                                                           |
| (0          | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | Funeral        | 11. Marital Status 1 □ Never Marrie                                                  | ed 2□ Married                            | 12. Was Deceder<br>Armed Force<br>1 ☐ Yes 2                 | s?                         | 11                             | Vas Decedent of F<br>Yes, specify Cub              | dispanic Orig<br>an, Mexican,  | gin? (Specify `<br>, Puerto Ricar | Yes or No-<br>n, etc.)                         | 14. Rac                          |                          | can Indian,<br>etc.                                       |
| 036         | ral", o                                                                                                                                                                                                                                             | by             | 3 XWidowed 4                                                                         | 1 ☐ Divorced                             | If Yes, Give<br>Year or Dates                               | s:                         | 1                              | ☐Yes 2XNo                                          | Specify:                       |                                   |                                                | Specif                           | <sup>Бу:</sup> В         | 1ack                                                      |
| 5-0         | 72 hc<br>'natu                                                                                                                                                                                                                                      | eted           | (Specia                                                                              | 15. Decedent's Ed<br>fy only highest gra | ducation<br>ade completed)                                  |                            | 16a. Deced                     | ent's Usual Occup                                  | oation                         | of working                        |                                                | 16b. Kind of B                   | usiness/In               | dustry                                                    |
| 21215-0036  | e filed within al Hygiene. I other than " vent, the Med                                                                                                                                                                                             | Completed      | Elementary/Secon                                                                     |                                          | College (1-40                                               | or 5+)                     | Homen                          | kind of work done<br>00 NOT use retire<br>1aker    | d)                             | or working                        |                                                | Privat                           | :e                       |                                                           |
| pu          | e file<br>al Hy<br>f othe                                                                                                                                                                                                                           | Be             | 17. Father's Name (F                                                                 | First, Middle, Last,                     | )                                                           |                            |                                |                                                    | 18. Mother                     | r's Name <i>(Firs</i>             | st, Middle, N                                  | Maiden Surnar                    | ne)                      |                                                           |
| yla         | 2 should be and Mental is marked o                                                                                                                                                                                                                  | To             | John Benj                                                                            | and the same of the same of the          |                                                             |                            |                                |                                                    |                                |                                   |                                                | Quarco                           |                          |                                                           |
| , Maryland  | 1 and 2 sh<br>Health and<br>tem 27 is m                                                                                                                                                                                                             |                | 19a. Informant's Nar<br>Ruth Quar                                                    |                                          |                                                             |                            |                                | g Address <i>(Street</i><br>Edenwoo                |                                |                                   | ute Number<br>wie, l                           |                                  |                          | o Code)                                                   |
| Baltimore,  | permit. Pages 1 an<br>Department of Heal<br>Important: If item 2<br>any Injury or other<br>once.                                                                                                                                                    |                |                                                                                      |                                          | (Removal from State                                         | te Uni                     | versit                         | sition (Name of<br>natory or other pla<br>Y OI Gna | ina o                          | Date 2-24-20                      | 200                                            | 20c. Location                    |                          |                                                           |
| Baltiı      | permit. P<br>Departm<br>Importar<br>any Injur                                                                                                                                                                                                       |                | 21. Signature of Fun                                                                 |                                          |                                                             | Med                        | 22.                            | Name and Addre                                     | ss of Facility                 | Marsh                             | all's                                          |                                  | 1 Hor                    | me, Inc.                                                  |
|             | 402 60                                                                                                                                                                                                                                              |                | 23a. Part1. Enter the                                                                | ///WW                                    | plications that cause                                       | end the death              | - $-$                          | 17 9th S                                           |                                |                                   |                                                | ngton,                           | DC :                     | 20011                                                     |
|             | Physician /Medical                                                                                                                                                                                                                                  |                | shock, or heart<br>Immediate Cause (F<br>disease or condition<br>resulting in death) | failure. List only                       | one cause on each                                           | vascul                     | ar Acc                         | ident du                                           |                                |                                   | •                                              | ,                                |                          | Approximate<br>Interval Between<br>Onset and Death        |
| è           | Examiner                                                                                                                                                                                                                                            | Į              | Sequentially list cond                                                               | ditions.                                 | b                                                           | as a consequ               | ,                              |                                                    |                                |                                   |                                                |                                  |                          |                                                           |
|             | sit sed                                                                                                                                                                                                                                             | Examiner       | cause. Enter Underl<br>Cause (Disease or in                                          | mediata                                  | Due to Lor a                                                | as a consequ               | ence of):                      |                                                    |                                |                                   |                                                |                                  |                          |                                                           |
|             | xecut<br>and<br>al-tran                                                                                                                                                                                                                             | xan            | that initiated events<br>resulting in death) La                                      |                                          | c<br>Due to (or a                                           | as a consequ               | ence of):                      | <del></del>                                        | _                              |                                   |                                                |                                  |                          |                                                           |
| 68760,      | icate be executed<br>physician and<br>s the bunal-transit                                                                                                                                                                                           | edical E       |                                                                                      | (                                        | d                                                           |                            |                                |                                                    |                                |                                   |                                                |                                  |                          |                                                           |
| _           |                                                                                                                                                                                                                                                     |                | IF FEMALE:                                                                           |                                          | "                                                           |                            |                                |                                                    |                                |                                   |                                                |                                  |                          |                                                           |
| P.O. Box    | The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as it.                                                                                                                            | Physician/M    | 23b. Was decedent print the past 12 mm 1 ☐ Yes 2 ☑ 9 ☐ Unknown                       | nonths?                                  | 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown | 2 ☐ Fetal<br>at time of de | death 3□                       | Ectopic pregnancy<br>Other (specify)               | /                              |                                   |                                                |                                  | te of delive<br>onth     | ery<br>Day Year                                           |
|             | that the led by detac                                                                                                                                                                                                                               |                | Part II. Other signific                                                              | cant conditions o                        | ontributing to death                                        | but not resu               | Iting in the un                | derlying cause giv                                 | en in Part I.                  | 2                                 | 23e. Did tob                                   | acco use cont                    | tribute to t             | he cause of death?                                        |
| Records,    | w requires<br>been sign<br>should be                                                                                                                                                                                                                | ted by         |                                                                                      |                                          |                                                             |                            |                                |                                                    |                                |                                   | 1 □ Ye                                         | es 2 🛛 No                        | 3 □ Prot                 | pably 4 □Unknown                                          |
| Rec         |                                                                                                                                                                                                                                                     | Completed      |                                                                                      |                                          |                                                             |                            |                                |                                                    |                                |                                   | 24a. Was ar<br>autops<br>perforn<br>☐ Yes 2    | y<br>ned?                        | prior to co<br>death?    | opsy findings available<br>mpletion of cause of<br>2 ☐ No |
| Vita        | sician; The certificate rector, pag                                                                                                                                                                                                                 | Be (           | 25. Was case referre examiner?                                                       | ed to medical                            |                                                             |                            |                                |                                                    |                                | of Death (Che                     |                                                |                                  |                          |                                                           |
| 7           | Physic<br>this c                                                                                                                                                                                                                                    | ြ              | 1 ☐ Yes 2 🔀 N                                                                        | 0                                        | Hospital: 1 ☐ Inpa                                          |                            | R/Outpatient                   |                                                    | 4 LI Nurs                      | sing Home                         | 5X Reside                                      | ence 6 DOth                      | er (Specil               | ý)                                                        |
| Division or | ding F                                                                                                                                                                                                                                              | ion:           | 27. Manner of Death<br>1 X Natural                                                   | 5 Pending                                | 28a. Date of In<br>(Month, E                                |                            | 28b. Time of<br>Injury         | 28c. Injur<br>Wor                                  |                                |                                   | Describe ho                                    | w injury occur                   | red                      |                                                           |
| S           | il or Attend<br>after death<br>Director: ,<br>d in by the f                                                                                                                                                                                         | icat           | 2 ☐ Accident<br>3 ☐ Suicide                                                          | investigation<br>6 ☐ Could not be        |                                                             | niury - At hor             | ne farm stre                   | M 1 □<br>et, factory, office                       | Yes 2 N                        |                                   | nontine (Ct                                    | and and Alvert                   | D                        | al Route Number,                                          |
| 2           | after<br>after<br>Dire<br>d in b                                                                                                                                                                                                                    | Certification: | 4 ☐ Homicide                                                                         | determined                               | building,                                                   | etc. (Specify,             | )                              | ot, 140tory, 011100                                |                                | 261. LC                           | ity or Town                                    | , State)                         | rer or nura              | ar Houte Number,                                          |
|             | Hospita<br>24 hours<br>Funeral<br>stely filled                                                                                                                                                                                                      | Medical C      | 29a. Certifier 1<br>(Check only 2<br>one) 2                                          | ☐ Certifying Ph                          | ysician: To the bes<br>niner: On the basis<br>and manner s  | of examinati               | rledge, death<br>on and/or inv | occurred at the tirestigation, in my c             | ne, date and<br>ppinion, death | l place, and d<br>h occurred at   | ue to the ca<br>the time, da                   | ause(s) and ma<br>ate and place, | anner as s<br>and due to | tated.<br>o the cause(s)                                  |
|             | To the within 2 To the complet                                                                                                                                                                                                                      | Me             | 29b. Signature and                                                                   | tle of certifier                         | and manners                                                 |                            |                                | 29c. Licens                                        | e number                       |                                   | 29                                             | 9d. Date signe                   | d (Month.                | Day, Year)                                                |
| )           |                                                                                                                                                                                                                                                     |                |                                                                                      | Kan                                      | . 1                                                         | MD                         |                                | D005                                               | 3709                           |                                   |                                                | ebruar                           | , ,                      | **                                                        |
| 1           | 2(10)                                                                                                                                                                                                                                               |                | 30. Name and addres                                                                  | ss of person who                         | -7                                                          |                            |                                | rint)                                              |                                | MD 2                              | 20715                                          | coruar                           | у 10,                    | 2000                                                      |
|             | Sta                                                                                                                                                                                                                                                 | te             | 31. Date filed (Month) FEB 1                                                         | , Day, Year)                             | 1                                                           | trar's Signati             | Ire                            | 116 210                                            | nowre,                         | , riv 2                           | .0/13                                          |                                  |                          |                                                           |
|             | Registra                                                                                                                                                                                                                                            | 11             | 1 LD X                                                                               |                                          | LOUNS.                                                      | 10 19                      | 41                             |                                                    |                                | ,                                 |                                                |                                  |                          |                                                           |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 26, WILLIAM CARROLL Feb. 2008 RICE unknown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1407 Rock Ridge Road Jarrettsville Harford If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year)

May 21 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months 1**X** M 2□ F 92 219-05-9559 Director 1915 Maryland Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2X No **Funeral Director** Harford MD. Jarrettsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with Heelth and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or ather traumatic event, the M dical Examiner must be r 1407 Rock Ridge Road 21084 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Harford County Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stillie Carroll Rice Creola Walton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If item 27 any injury or other tra (Wife) Mabel E. Hart-Rice 612 Union Ave. Havre de Grace, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) James Cemetery 3/4/2008 Jarrettsville, MD. 21. Signature of Funegal/Service Licensee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** vebrova /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed Due to (or as a consequence of) Box 68760. ettending physician Physiclan/Medical as the l 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 0 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the e Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 W 24a. Was an has autopsy certificate 1□ Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 No within 24 hours after open..

To the Funeral Director: After this of 2 1 ☐ Yes 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who ise of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State MAR 0 Registrar

|                |                                                                                                                                             |                | For<br>State<br>Registrar                                                                                   | State of Mar                                     |                                  | artment<br><i>rtificate</i> |                    |              | and Me      | ental Hy                         | giene        | 008                               | 0                                            | 6485                                 |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------|-----------------------------|--------------------|--------------|-------------|----------------------------------|--------------|-----------------------------------|----------------------------------------------|--------------------------------------|
|                | Physici                                                                                                                                     | an             | 1. Decedent's Name (First, Middle, Las                                                                      | > ~.                                             |                                  |                             |                    |              |             | 2. Date of De                    | Day.         | Year                              |                                              | ime of Death                         |
| 7              | /Medic                                                                                                                                      |                | Kussell                                                                                                     | ruggel'i                                         | <u>O</u>                         | T at =                      |                    |              | 15 11       | 2                                | 10           | ounty of Dear                     | V                                            | 1:01 PM                              |
| 1              | Examin                                                                                                                                      | er             | 4a. Facility Name (If not institution, give                                                                 | el-tiosof                                        | -1                               | 46. City, 1                 | lown, or           | Location of  | A A T       |                                  |              | or ces                            | 4                                            |                                      |
| H              | Funeral                                                                                                                                     |                | 5. Social Security Number 6. Se                                                                             |                                                  | 'In yrs. last birthday)          | If Under                    |                    | If Under     |             | 8. Date of Bi                    | rth          | 9. Bir                            | holace (S                                    | State or Foreign                     |
|                | Director                                                                                                                                    |                | 156-28-8477                                                                                                 | ØM 2□F 6                                         | 9 Yrs.                           | Months                      | Days               | Hours        | Min.        | (Month, Da                       | 1938         | New                               | i Jer                                        | sey                                  |
|                | pur                                                                                                                                         |                | Usual Residence of Decedent  10a. State 10b. County                                                         | 1                                                | 0c. City, Town or Lo             | ocation                     |                    |              |             |                                  |              |                                   | 10d Ins                                      | ide City Limits                      |
|                | Aaryla<br>Fehor                                                                                                                             | ō              |                                                                                                             |                                                  |                                  |                             |                    |              |             |                                  |              |                                   |                                              | Yes XX No                            |
|                | after death with the Marylan<br>or iteme 23a or 28e-1 ehow<br>inter invest be notified at                                                   | Director       | MD Worceste                                                                                                 |                                                  | Ocean Cit                        | 10f. Zip (                  | Code               |              |             |                                  | 10g. Citizer | n of What Co                      | untry?                                       |                                      |
|                | h with                                                                                                                                      | al D           | 2 Dorchester Str                                                                                            | eet unit 70                                      | 01                               | 21                          | 842                |              |             |                                  |              | USA                               |                                              |                                      |
|                | deat                                                                                                                                        | Funeral        | 11. Marital Status                                                                                          | 12. Was Decedent Ev<br>Armed Forces?             |                                  | Was Decede                  | ent of His         | spanic Orig  | gin? (Spec  | cify Yes or No<br>Rican, etc.)   | o- 14.       | Race - Ame<br>Black, Whit         |                                              | an,                                  |
| 36             | hours after death with the Maryland<br>turel', or iteme 23a or 28e-f ehow<br>al Examirer must be matified at                                | by Fu          | 1 Never Married 2 Married                                                                                   | 1 ☐ Yes 2 ☑ No<br>If Yes, Give                   |                                  | 1 ☐ Yes 2                   |                    |              |             |                                  |              | ecity: W                          |                                              |                                      |
| 21215-0036     | hours<br>furel                                                                                                                              | ed b           | 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed.                                                                | Year or Dates:                                   |                                  | dent's Usual                |                    |              |             |                                  | 16b Kind     | of Business                       | Industry                                     |                                      |
| 15             | n nat                                                                                                                                       | plet           | (Specify only highest grad                                                                                  |                                                  | (Give                            | kind of worl<br>DO NOT use  | k done d           | urina most   | t of workin | g                                |              |                                   |                                              |                                      |
| 212            | d within<br>giene.<br>er than "                                                                                                             | Completed      | 12                                                                                                          | College (1-401 5+)                               | Self                             | Emplo                       | ved                |              |             |                                  | Buss         | iness                             | owne                                         | er                                   |
|                | be filed<br>tal Hygi<br>of other<br>event, I                                                                                                | Be             | 17. Father's Name (First, Middle, Last)                                                                     |                                                  |                                  |                             | 3                  |              |             | (First, Middle                   | •            | mame)                             |                                              |                                      |
| χ              | Men                                                                                                                                         | 10             | Joseph Ruggerio                                                                                             |                                                  |                                  |                             |                    |              |             | Alizzo                           |              | 21.1                              |                                              |                                      |
| Maryland       | d 2<br>h a<br>7 ts                                                                                                                          |                | 19a. Informant's Name/Relationship (7)                                                                      |                                                  |                                  |                             |                    |              |             | Route Numb<br>it 701             |              |                                   |                                              |                                      |
|                | s 1 and 2<br>if Health<br>item 27<br>other tra                                                                                              |                | Nancy A. Ruggerio<br>20a. Method of Disposition                                                             | - Mother                                         | 20h Place of Disor               | sition /Nam                 | e of               |              |             | ate / U I                        | 20c. Local   | tion - City or                    | Town, St                                     |                                      |
| e<br>e         | Pages<br>nent of<br>int: If it                                                                                                              |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify                                                | Removal from State                               | Cape Hend                        | a Tope "                    | Creii              | 1.           | Feh         | 18, 08                           | Frank        | ford,                             | DE                                           |                                      |
| Baltimore,     | permit. Pages<br>Depertment of<br>Important: If it<br>eny Injury or o                                                                       |                | 21. Signature of Funeral Service Licens                                                                     | ee                                               | 2                                | 2. Name and                 | d Addres           |              |             | bage 1                           |              | 1 home                            | <u>.                                    </u> |                                      |
| <u> </u>       | 897 2 8                                                                                                                                     |                | 1 Jun L                                                                                                     | Indag-                                           |                                  |                             |                    |              | treet       | Berli                            | in, MD       |                                   |                                              |                                      |
|                |                                                                                                                                             |                | 23a. Part 1. Enter the disease, or comp<br>shock, or heart failure. List only of                            | lications that caused the ne cause or each line. | e death. Do not en               | ter the mode                | of dying           | such as      | 11          |                                  |              |                                   | Interv                                       | oximate<br>al Between<br>t and Death |
| the same       | Physician /Medical                                                                                                                          |                | Immediate Cause (Final disease or condition resulting in death)                                             | a Opper                                          | · gastn                          | sinte                       | 5+11               | nat          | 616         | redin                            | 9            |                                   | 20                                           | lays                                 |
|                | Examiner                                                                                                                                    |                |                                                                                                             | Due to (or as a o                                | consequence of):                 |                             |                    |              |             | _                                | /            |                                   |                                              | ·                                    |
|                | <u> </u>                                                                                                                                    | Jer            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a c                             | consequence of):                 |                             |                    |              |             |                                  |              |                                   |                                              | <del></del>                          |
|                | cuted<br>nd<br>ransit                                                                                                                       | Examine        | that initiated events                                                                                       | c                                                |                                  |                             |                    |              |             |                                  |              |                                   |                                              |                                      |
| 0,             | ate be executed thysicien and the burial-transit                                                                                            |                | resulting in death) Last                                                                                    | Due to (or as a                                  | consequence of):                 |                             |                    |              |             |                                  |              |                                   |                                              |                                      |
| 8760,          | cate b<br>physic<br>the b                                                                                                                   | dlcal          | •                                                                                                           | d                                                |                                  |                             |                    |              | -           | •                                |              |                                   |                                              |                                      |
| 9 x            | death certifical<br>e attending phy<br>od for use as th                                                                                     | √Me            | IF FEMALE:                                                                                                  | 23c. If yes, outcome of                          | pregnancy                        |                             |                    |              |             |                                  | 230          | I. Date of de                     | ivery                                        |                                      |
| Box            | death<br>a atter<br>d for u                                                                                                                 | Iclar          | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 □ No                                      | 1□Live birth 2  <br>4□Pregnant at tir            |                                  | Ectopic pre Other (spe      |                    |              |             |                                  |              | Month                             | Day                                          | Year                                 |
| P.0.           | thet the di<br>ed by the<br>deteched                                                                                                        | Physician/Med  | 9 Unknown                                                                                                   | 9LJ Unknown                                      |                                  |                             |                    |              |             |                                  |              |                                   |                                              |                                      |
|                | law requires thet the<br>es been signed by th<br>2 should be deteche                                                                        | ру Р           | Part II. Other significant conditions co                                                                    |                                                  |                                  | nderlying ca                | use give           | n in Part I. |             |                                  | tobacco use  |                                   |                                              | 1/1                                  |
| Vital Records, | requir<br>een si                                                                                                                            |                | Cholangia                                                                                                   | carcin en                                        | ma                               |                             |                    |              |             | 1                                | Yes 2 X      | No 3∐Pi                           | obably                                       | 4 Unknown                            |
| Sec.           | e law<br>hes b                                                                                                                              | Completed      |                                                                                                             |                                                  |                                  |                             |                    |              |             | 24a. Was                         |              | 4b. Were au<br>prior to<br>death? | topsy fine<br>completio                      | dings available<br>n of cause of     |
| a<br>E         | The ete                                                                                                                                     |                | 05.11                                                                                                       |                                                  |                                  |                             |                    |              |             | 1 Yes                            | 2 No         | 1 🗆 Yes                           | 2KN                                          | 0                                    |
| ₹              |                                                                                                                                             | To Be          | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No                                                  | Hospital: 1 Npatient                             | 2 ER/Outpatier                   | nt 3 DO                     | Othe               | <i>c</i>     |             | <i>(Check only</i><br>ne 5⊟ Resi |              | Other (Sne                        | cifu)                                        |                                      |
| 100            | g Phys<br>er this<br>neral di                                                                                                               |                | 27. Manner of Death                                                                                         | 28a. Date of Injury<br>(Month, Day Y             | 28b. Time o                      |                             | Bc. Injury<br>Work |              |             | 8d. Describe                     |              |                                   | c.i.y)                                       | ,                                    |
| Sior           | Attending of death.                                                                                                                         | atlo           | 1 Natural 5 Pending investigation                                                                           |                                                  | , ,,,,,,                         | м                           |                    | es 2 🗆 1     | No          |                                  |              |                                   |                                              |                                      |
| Division       | or Att                                                                                                                                      | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined                                                           | 28e. Place of Injury<br>building, etc.           | - At home, farm, st<br>(Specify) | reet, factory,              | , office           |              | 2           | 8f. Location (<br>City or To     |              | lumber or Ri                      | ural Route                                   | Number,                              |
|                | To the Hospital or Attending Ph<br>within 24 hours efter death.<br>To the Funeral Director: Atter th<br>completely filled in by the funeral |                | 29a. Certifier 12 Certifying Phy                                                                            | sician: To the best of a                         | mv knowledge deat                | h occurred a                | it the time        | e. date an   | d place a   | nd due to the                    | Causals) an  | d manner as                       | stated                                       |                                      |
|                | Me Hos                                                                                                                                      | Medical        | (Check only 2 Medical Exam                                                                                  | ner: On the basis of ex<br>and manner state      | camination and/or in             | vestigation,                | in my op           | inion, deal  | th occurre  | d at the time,                   | date and pla | ace, and due                      | to the ca                                    | ause(s)                              |
|                | To the within 2 To the complet                                                                                                              | Me             | 29b. Signature and title of certifier                                                                       | Λ                                                |                                  | 29c.                        | License            | number       |             |                                  | 29d. Date s  | igned (Mont                       | h. Day, Y.                                   | ear)                                 |
|                |                                                                                                                                             |                | George Da                                                                                                   | in Kee                                           | de mo                            | > [                         | >00                | 162          | 670         |                                  | 2/           | 162                               | 008                                          |                                      |
| R              | AIA                                                                                                                                         |                | 30. Name and address of person who                                                                          |                                                  | th (Item 23a) (Type,             | Print)                      | 11.                | L 1 <        | 21          | Pocom                            | 1            | 115                               | 216-                                         |                                      |
|                | Sta                                                                                                                                         | to             | 31. Date filed (Month, Day, Year)                                                                           | See der 10<br>32. Bigistrar's                    | Signature                        | 1-11/                       | viar               | ret.         | <b>T</b>    | locom                            | oke, 1       | (V) 0                             | 00                                           | i                                    |
|                | Registr                                                                                                                                     |                |                                                                                                             | 08 Males                                         | J. S. A.                         | 0342                        | :                  |              |             |                                  |              |                                   |                                              |                                      |

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending changing consistent and the funeral Director. Division or Vital Records, P.O. Box 68760,

|                                                                                                       |                   | Please T                                                                                                                                                                                           | ype or Print in E                                                                            |                                                    |                                                            |                                                         |                                   | _                      | ole.                                                                              |  |  |
|-------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------|-----------------------------------|------------------------|-----------------------------------------------------------------------------------|--|--|
|                                                                                                       |                   | For<br>State<br>Registrar                                                                                                                                                                          | State of Marylan                                                                             |                                                    | rtificate of                                               |                                                         | , ,                               | eg. No. 2 ()           | 08 06486                                                                          |  |  |
| ysici<br>Media                                                                                        |                   | 1. Decedent's Name (First, Middle, Last)  Amelia Ethel Rich                                                                                                                                        | ardson                                                                                       |                                                    |                                                            |                                                         | 2. Date of Deat<br>Month          | Day                    | 3. Time of Death Year O350AM                                                      |  |  |
| viedit<br>tamin                                                                                       |                   | 4a. Facility Name (If not institution, give s                                                                                                                                                      | treet and number)                                                                            |                                                    |                                                            | Location of Death                                       |                                   | 4c. County of          |                                                                                   |  |  |
|                                                                                                       |                   | Anne Arundel Medic  5. Social Security Number 6. Sex                                                                                                                                               |                                                                                              | lact hirthday)                                     | Annapol i                                                  |                                                         | 8. Date of Birth                  | Anne                   | Arundel  9. Birthplace (State or Foreign                                          |  |  |
| eral<br>ector                                                                                         |                   | 230-28-6787  Usual Residence of Decedent  1 M 2 MF 84 Yrs. Months Days Hours Min. (Month, Day, Year) Aug. 7, 1923 Vin                                                                              |                                                                                              |                                                    |                                                            |                                                         |                                   |                        |                                                                                   |  |  |
| dat                                                                                                   | )r                | 10a. State 10b. County                                                                                                                                                                             |                                                                                              | y, Town or Lo                                      | cation                                                     |                                                         |                                   |                        | 10d. Inside City Limits 1 XYes 2 □ No                                             |  |  |
| e notifle                                                                                             | Funeral Director  | Maryland Prince G                                                                                                                                                                                  | eorge's   Bow                                                                                | Bowie 10f. Zip Code 1                              |                                                            |                                                         |                                   |                        | hat Country?                                                                      |  |  |
| ust b                                                                                                 | rall              | PO BOX 347 Lloyd S                                                                                                                                                                                 |                                                                                              |                                                    | 20715                                                      |                                                         |                                   | USA                    |                                                                                   |  |  |
| any Injury or other traumatic event, the Medical Examiner must be notifled at once.                   | by Fune           | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced                                                                                                                        | <ul> <li>Was Decedent Ever in U. Armed Forces?</li> <li>1 ☐ Yes 2 No If Yes, Give</li> </ul> |                                                    | Was Decedent of H<br>If Yes, specify Cuba<br>1 □ Yes 2X No | ispanic Origin? (Spe<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)  |                        | - American Indian,<br>k, White, etc.                                              |  |  |
| al Ex                                                                                                 | Completed b       | 15. Decedent's Educ                                                                                                                                                                                | Year or Dates:                                                                               | 16a. Decedent's Usual Occupation 16b. Kind of Busi |                                                            |                                                         |                                   | USA<br>siness/Industry |                                                                                   |  |  |
| Medic                                                                                                 | plet              | (Specify only highest grade Elementary/Secondary (0-12)                                                                                                                                            | completed) College (1-4or 5+)                                                                | (Give<br>life.                                     | kind of work done on<br>DO NOT use retired                 | during most of worki<br>d)                              |                                   | Own Hom                |                                                                                   |  |  |
| ıt, the                                                                                               |                   | 12                                                                                                                                                                                                 |                                                                                              | Home Maker  18. Mother's Name (First, Middle, I    |                                                            |                                                         |                                   |                        |                                                                                   |  |  |
| even                                                                                                  | Be C              | 17. Father's Name (First, Middle, Last)                                                                                                                                                            |                                                                                              |                                                    |                                                            | Nora Alic                                               | •                                 | naiden Sumame          | <i>3)</i>                                                                         |  |  |
| ımatic                                                                                                | ပ္                | John Wesley Hall  19a. Informant's Name/Relationship (Type                                                                                                                                         | pe. Print)                                                                                   | 19b. Mailir                                        | ng Address (Street                                         | and Number or Rura                                      |                                   | ; City or Town, S      | State, Zip Code)                                                                  |  |  |
| er trau                                                                                               |                   | Janice E. Kay/ Dau                                                                                                                                                                                 | ghter                                                                                        | 2247                                               | Kings La                                                   | anding Roa                                              | ad Hunti                          | ngtown,                | MD 20639                                                                          |  |  |
| or oth                                                                                                |                   | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re                                                                                                                                         | emoval from State                                                                            | lace of Dispo<br>emetery, crei<br>Fort L           | sition (Name of<br>natory or other plac<br>incoln          | ce)                                                     |                                   |                        | City or Town, State                                                               |  |  |
| Injury                                                                                                |                   | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License                                                                                                                         |                                                                                              | Ceme                                               | tery  2. Name and Addre                                    | 2/14/                                                   |                                   | Brentwo                | od, MD<br>Funeral Home                                                            |  |  |
| any                                                                                                   | L                 | > Kuth                                                                                                                                                                                             | 7                                                                                            |                                                    |                                                            | apolis Roa                                              |                                   |                        |                                                                                   |  |  |
| cian<br>lical                                                                                         |                   | 23a. Part1. Enter the disease, or compositions, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)                                                     | e cause on each line.                                                                        | eume                                               | csea Cours                                                 | ig, such as cardiac d                                   | or respiratory arre               | est,                   | Approximate<br>Interval Between<br>Onset and Death                                |  |  |
| ne burial-transit                                                                                     | ical Examiner     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Urbades or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c |                                                                                              |                                                    |                                                            |                                                         |                                   |                        |                                                                                   |  |  |
| completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown                                                                                                            | 3c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown  | Ideath 3                                           | ⊒Ectopic pregnancy<br>] Other <i>(specify)</i> _           | ,                                                       |                                   | 23d. Date<br>Mon       | e of delivery<br>tth Day Year                                                     |  |  |
| uld be deta                                                                                           | ρ                 | Part II. Other significant conditions con                                                                                                                                                          | tributing to death but not resu                                                              | ulting in the u                                    | nderlying cause giv                                        | en in Part I.                                           |                                   |                        | bute to the cause of death?  3 Probably 4 ZUnkhown                                |  |  |
| oage 2 sho                                                                                            | Completed         |                                                                                                                                                                                                    |                                                                                              |                                                    | <del>.</del>                                               |                                                         | 24a. Was all autops perform       | ned? p                 | Vere autopsy findings available nor to completion of cause of eath?  ☐ Yes 2 ☐ No |  |  |
| ctor, p                                                                                               | Bec               | 25. Was case referred to medical examiner?                                                                                                                                                         |                                                                                              |                                                    |                                                            | 26. Place of Death                                      |                                   |                        |                                                                                   |  |  |
| al dire                                                                                               | 은                 | 1 Yes 2 Ne                                                                                                                                                                                         | lospital: 1 ☐ Inpatient 2 ☐  28a. Date of Injury                                             | 28b. Time o                                        |                                                            | 4 U Nursing Ho                                          | me 5 Reside                       |                        |                                                                                   |  |  |
| funera                                                                                                | ion:              | 27. Manner of Death  1 ☑ Hatural 5 ☐ Pending 2 ☐ Accident investigation                                                                                                                            | (Month, Day Year)                                                                            | injury                                             | Wor                                                        | yai<br>k?<br>Yes 2∐No                                   | 28d. Describe ho                  | w injury occurre       | ed                                                                                |  |  |
| in by the                                                                                             | Certification:    | 3 Suicide 6 Could not be determined                                                                                                                                                                | 28e. Place of injury - At ho building, etc. (Specify                                         | ome, farm, str                                     | eet, factory, office                                       |                                                         | 28f. Location (St<br>City or Town |                        | er or Rural Route Number,                                                         |  |  |
| pletely fillec                                                                                        | Medical C         |                                                                                                                                                                                                    | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated.          | tion and/or in                                     | vestigation, in my                                         | ppinion, death occur                                    | red at the time, d                | ate and place, a       | and due to the cause(s)                                                           |  |  |
| шоо                                                                                                   | Σ                 | 29b. Signature and title of certifier                                                                                                                                                              | aufAC                                                                                        |                                                    | 29c. Licens                                                | e number                                                | 2                                 | 9d. Date signed        | (Month, Day, Year) IOOO Annopelis, Y. MD                                          |  |  |
| 5 <sub>w</sub>                                                                                        |                   | 30. Name and address of person who co                                                                                                                                                              | mpleted cause of death (Item                                                                 | n 23a) (Type,<br>Lindall                           | Med C                                                      | tr. 2100                                                | Medica                            | 1 Pkw                  | Annoytelis,                                                                       |  |  |
| Sta<br>egisti                                                                                         | ite               | 31. Date filed (Month, Day, Year)<br>FEB 1 3 2008                                                                                                                                                  | Registrar's Signa                                                                            | iture                                              | de                                                         |                                                         |                                   |                        |                                                                                   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13 Day Month **Physician** 2008 950 INTHIA TED. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner WICSMICO SAUSOUR MAINSHLA REGIONAL If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Min 1 □ M 2 □XF Hours 47 217-74-0490 Director 3/29/1960 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA 31054 Dagsboro Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Widowed 4 Divorced white natural d Hygiene. d other than "natura" event, the Medical E 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Salisbury Elementary/Secondary (0-12) College (1-4or 5+) Christian School 12 administrative assistant Item 27 is marked othe other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Loretta Wagner Raymond LaBounty ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ricky A. Reddish/husband 31054 Dagsboro Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of the Important: If ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Reddish Family 2/17/08 Salisbury, MD 4 Donation 5 Other (Specify) Cemetery ame and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sneast **Physician** Camera disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be o 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 rector, page 2 ₽ No 1□ Yes director. 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death Natural Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) Injury

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: funeral After

death with

altimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:
completely filled in by the t

Medical Certification: 29b. Signature and title of certifie

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

6 ☐ Could not be determined

5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

Shone Da.

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 10 2008 **Physician** 4:55 P M EARNEST SPEIGHT /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 9131 7TH ST. LANHAM PRINCE GEORGE'S Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Months Hours Min Director 237-52-1309 74 8/4/1933 NORTH CAROLINA Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at XXYes 2□No Director MD PRINCE GEORGE'S LANHAM 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9131 7TH ST. 20706 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. Specify. If Yes, Give Year or Dates: <u>م</u> 3 X Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) MECHANIC PRIVATE 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be l and 2 should be fi Health and Mental H CHARLES SPEIGHT AUGUSTA LEECH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TRACY SPEIGHT/ SON 9131 7TH ST. LANHAM, MD 20706 f Health 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/19/08 RIVERDALE, MD RIVERDALE CREMATORY Injury 4 Donation 5 Dother (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee any 7474 LANDOVER RD. LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Immediate Cause (Final Htherosch **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death nse 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy jo Month Year in the past 12 months? Day 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 3 ☐ Probably → ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2□ No Physician: 25. Was case referred to medical examine??
1. ✓ Yes 2 \sum No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □ No 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient P this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Director: After Injury Hospital or Attending 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signa 31. Date filed (Month, Day, Year) State 2008 19 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Ruth Elizabeth Spriggs February 13, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heartlands of Severna Park Severna Park Anne Arundel 8. Date of Birth (Month, Day, Year) July 18, 1907 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 200 100 220-36-1827 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show Maryland Anne Arundel Arnold 1 ☐ Yes 2 X No Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21012 965 Bayberry Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 'n, Maryland 21215-0036 1 ☐ Yes 2 No White Specify 2 3€XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be I Department of Health and Mental I Important: If item 27 Is marked o Curtis Garrott Sally Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lynne Hatch/Friend and POA 928 Bayberry Drive Arnold, Maryland Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Asbury U.M. Cemetery 2/19/2008 Arnold, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fanieral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ugars **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? Month 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) assiste a Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Hwy Millersville, MS

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 🗋 🧎 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 12, 2008 3:30pm м Betty Lee Robbins Seiland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville Carroll 7200 Third Avenue C-66 if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 5, 192 **Funeral** Days Months Hours 1 ☐ M 2 🔽 F 79 217-24-5745 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Medical Examiner must be notified at 1 ☐ Yes 2X No Sykesville MD Carrol1 Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ death with USA 21784 7200 Third Avenue C-66 'natural', or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Λ Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exemines, once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 ☐ No Specify. White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Curtis Robbins/ Susie East 19a Informant's Name/Relationship (Type. Print) (Children)
J. Craig Seiland, Robin Trenner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) c/o: 9474 Lovat Road Fulton, MD 20759 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/16/2008 Mt. Holly Cemetery Onancock, VA Mook4 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)
Sykesville, MD 21784 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) rearc **Physician** 179 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; of completely filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of pertified WIL 20 completed cause of death (Item 23a) (Type, Print) 295 Stoner 31. Date filed (Month, Day, State FEB 15 2008 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12, 2008 **Physician** George Raymond Sauble, Jr. February 8:20 a M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll Hospice Dove House 8. Date of Birth (Month, Day, Year) 1. 1929 Westminster Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X**M 2□ F 79 Yrs. Maryland 217-28-1342 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County show 'natural", or items 23a or 28a-f shov dical Examiner must be notified at Union Bridge Carroll 1 ☐ Yes 2 No Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21791 USA 1829 Clearview Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No 3altimore, Maryland 21215-0036 Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NASA Mathematician es 1 and 2 should be filed vor Health and Mental Hygie of Hem 27 is marked other tor other traumatic event, the other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Estelle Koons George Raymond Sauble 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1829 Clearview Road, Union Bridge, MD 21791 19a. Informant's Name/Relationship (Type. Print) Doris E. Sauble, wife nt of Health a : If Item 27 is 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö Department or Important: If any Injury or Trinity Lutheran Cem 2/16/2008 Taneytown, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 136 E, Baltimore St, Taneytown, MD 21787 23a. Part. Enter the disease, or complications that caused the death. shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ul c year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the aftending ph for use as the 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. ģ 1 | Yes 2 | No 3 | Probably 4 DUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 28b. Time of 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760, e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica funeral filled in by within 24 ho To the Fune completely f 2 1

IOTIVA

Medical

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH GREENE St. BAILTIMORE, MD MD 22 BAER

2008

31. Date filed (Month, Day, Year)

FEB 14

6 ☐ Could not be

determined

32. Registrar's Signature

and manner stated

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0065598

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:32 PM 02 James A. Snyder /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** alisbur Wicomico Hospice at | Funder 1 Year | If Under 24 Hrs. | A. Date of Birth (Month, Day, Year) | Sep. 16, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1**X**XM 2 ☐ F Sep. PA 177-32-8985 1942 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Ocean City Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21842 USA #56 12626 Sunset Ave. by Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc 1 Types 2 No 1959 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No white Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Gov. Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin F. Snyder Melda K. Grav 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12626 Sunset Ave. #56 Ocean City, MD 21842 Beverly K. Snyder - Wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Cape Hena Tope Crem. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-16-08 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Burbage Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Ligans 108 William Street Berlin, MD 21811 23a. Pani. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pronths? Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 2 ER/Outpatient 3 DOA 1 Tes Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examiner and manner stated mation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif

State Registrar

James A.

31. Date filed (Month, Day,

FEB 1 9

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

State of Maryland / Department of Health and Mental Hygiene For State
RegistraMEND#2,perMD,2/22/08,DPS,McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mont Converse, 12, 2008 3. Time of Death **Physician** Рм 1200 February 11, 2008 Marvin H. Stein /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 7, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1∏ M 2□ F 80 1927 508-20-8260 Nebraska Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1 TyYes 2 □ No Director Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with U . S . A .

14. Race - American Indian,
Black, White, etc. 20906 3252 Gleneagles Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 🙀 Married 2 🗆 No Army 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced 'natural' WW 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Government Employee U. S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Eva Alpern Maurice Stein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Item 27 i Miriam M. Stein - Wife 3252 Gleneagles Drive, Silver Spring, Md. 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Acremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/18/2008 Falls Church, Virginia National Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland Donald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ZHEIMER DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of: at any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nunknown COKUNARY ARTERY 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2) No 1 Yes 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier M.D 30. Name and address of porson who completed cause of death (Item 23a) (Type, Print) HOSPITAL, 18/01 PRINCE PHILIP DR., OLNEY, MD 20832 TSAY MONTGOMERY GENERAL HENRY Registrar's Signature 31. Date filed (Manth, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:41 p M February 13 2008 Schlosburg Geraldine /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 15101 Interlachen Drive, #720 Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🕱 F December 22,1921 Illinois Director 578-12-3633 86 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f shoved at Examiner must be notified at 1 ☐ Yes 2 🕱 No Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15101 Interlachen Drive, #720 20906 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Caucasian ģ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry item 27 Is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edthye Diamond Dinny Diamond P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Schlosburg - Son 19713 Webster Court, Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State any injury or King David Memorial Gardens 02/15/2008 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 11/2 23a. Part1. Filer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 5 years Alzheimer Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-trai Due to (or as a consequence of): attending physician for use as the buriz Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ☐Yes 2 No detached the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2X No 3 Probably 4 Unknown 1 ☐ Yes Angina Pectoris Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 certificate Be 25 Certification: To 27

death certificate be executed Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the

|                                                           |                             |                                |                                                                                                             |                                     | performed?<br>1 Yes 2 No                          | death?<br>1 ☐ Yes 2 ☐ No      |  |  |  |  |  |  |
|-----------------------------------------------------------|-----------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------------|-------------------------------|--|--|--|--|--|--|
| 25. Was case refer                                        | red to medical              |                                | 26. Place of Death (Check only one)                                                                         |                                     |                                                   |                               |  |  |  |  |  |  |
| examiner?<br>1 🗌 Yes 2 🔀                                  | No                          | Hospital: 1 ☐ Inpatient 2 ☐    | dospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) |                                     |                                                   |                               |  |  |  |  |  |  |
| 27. Manner of Deatl<br>1 <b>X</b> Natural<br>2 ☐ Accident | 5 ☐ Pending investigation   |                                | 28b. Time of<br>Injury<br>M                                                                                 | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury                          | occurred                      |  |  |  |  |  |  |
| 3 ☐ Suicide<br>4 ☐ Homicide                               | 6 ☐ Could not be determined |                                | ome, farm, street, fac<br>fy)                                                                               | ctory, office                       | 28f. Location (Street and<br>City or Town, State) | Number or Rural Route Number, |  |  |  |  |  |  |
| 29a, Certifier                                            | 1 X Certifying Pl           | hysician: To the best of my kn | owledge, death occur                                                                                        | red at the time, date and p         | lace, and due to the cause(s) a                   | and manner as stated.         |  |  |  |  |  |  |

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of pertifier

29c. License number 29d. Date signed (Month, Day, Year)

D37975

February 14, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey P. Indrisano, M.D., 6410 Rockledge Drive, Suite #401, Bethesda, Maryland 20817

State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 15 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 13, 2008 9:45 am Milton S. Schechter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 08/09/1915 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 X M 2 □ F Days Hours New York 92 217-44-2384 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Silver Spring Directo Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? u.s.A. 20901 10909 Hannes Court Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Be Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Research Chemist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris Schechter Julia Bittner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10909 Hannes Ct., Silver Spring, MD 20901 Katherine Schechter - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lebanon Cemetery 02/15/2008 | Adelphi, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD20904 21. Signature of Funeral Service Licens Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Failure to Thrive disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Progressive Myoclonus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit be executed Pneumonia Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Pleural Effusion 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibullation 24a. Was an After this certificate has autopsy performed? 2 X No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 Pending To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 13, 2008 D60826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd., Silver Spring, MD Kshama Garg, M.D., 31. Date filed (Month, Day, Year) FEB 15 2008 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** 80/AM 2 BRUARY STUCKEY 2000 Ε. DONALD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days PÁ. 65 JULY 15,1942 Director 215-38-3283 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1√ Yes 2 No **Funeral Director** PRINCE GEORGES LAUREL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8704 CHAR COURT #14 20708 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 N Yes 2 No If Yes, Give Year or Dates: 1961-1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify Specify: Completed by WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HEATING & AIR CONDITIONING SELF EMPLOYED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STUCKEY DOROTHY REDINGER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) EDITH STUCKEY/WIFE 8704 CHAR COURT #14, LAUREL, MD. 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 2-18-2008 RIVERDALE, MD. 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P. A 20737 M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) MID - BRAIN STROKE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ARDIOVASCULAR 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsv performed' 2 40 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 hpatient 2 ER/Outpatient 3 DOA Medical Certification: To

Physician /Medical Examiner

21215-0036

Baltimore,

death certificate be executed

burial-tran the attending pr signed be pet page 2

Hospital or Attending within 24 hours after death

To the Funeral Director;
completely filled in by the

Division or Vital Records, P.O. Box 68760

To the I within 24 To the F

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29b. Signature and title of certifier

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only

4 Homicide

MD

and manner stated.

29c. License number D0050951 29d. Date signed (Month, Day, Year) 12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENILWORTH AVE, SUITE 2400 RIVERDALE MOST REVA 6510 GILL

31. Date filed (Month, Day, Year)

FEB 14 2008



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** <u>12:</u>50 ₽<sup>M</sup> Ethel Tate Smith February 9, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospital Laure1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🙀 F 92 23, 1915 Washington, DC Director 577**–**60**–**3842 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ¥ Yes 2 □ No Directo Washington N/A DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20011 U.S. 5520 Chillum P1., N.E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married African-Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛣 No Specify: Specify by 3 ☑ Widowed 4 ☐ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Veterans Adm. Staff Federal Government 4 other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carlotta Sayua Walter P. Tate 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Appleby Court, Silver Spring, MD 20904 Ronald M. Williams / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State 2/15/08 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery Washington, 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licens 10, 7400 Georgia Ave., N.W. Washington, D.C. 20012 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🖾 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√2 No 2 ER/Outpatient 3 DOA 2 1X Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 🙀 Natural To the Hospital or Attendir within 24 hours atter death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 ☐ Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D aFebruary 9, 2008 D0060936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Vandusen Road, Laurel, MD 20707 Abdul M. Tak, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 14 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 00:19 AM FEBRUARY 13 2008 STEVENSON SAMUEL 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL ONLEY MONTGOMERY 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
MARCH 23 1941 WASHINGTON, DC 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min **1** M 2 □ F 66 579-50-8345 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 XYes 2 No SILVER SPRING MONTGOMERY MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20906 3118 WHISPERING PINE DRIVE # 43 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 12th PLANT ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CLEON E. JOHNSON SAMUEL L. STEVENSON, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3118 WHISPERING PINE DRIVE # 43 SILVER SPRING, MD 0906 JOY A. CLAY/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/21/2008 RIVERDALE, MARYLAND RIVERDALE CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between 23a. Part1. Enter the disease shock, or heart failure. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 2 1 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1 70 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ OOA 1 ☐ Yes 2 ☐ No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

and Mental Hygiene.

Pages 1 and 2 should nent of Health and Mer

Health a

Item 27 is marked other other traumatic event,

Important: If it any injury or o once.

Director

Completed by Funeral

Be

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be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical þ

burial-tran physiciar the the nding p 38 esn Por the hed signed by t peen has page ; certificate this

The law requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

or Attending Physician:

after

the Funeral Director: npletely filled in by the Hospital within 24 hours Medical completely State Registrar

Completed Be ို After thi funeral ( Certification:

> 29b. Signature and title of pmpleted cause of death (Item 23a) 30. Name and address of

5 Pending investigation

6 ☐ Could not be determined

29c. License number

Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DRIVE, SILVER SPRING

31. Date filed (Month, Day, Year)

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

and manner stated.

DHMH 17 Rev 1/2001

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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|       | Physicia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                   | Decedent's Name (First, Middle,Last)                                                               |                                                     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | Date of Deat     Month                       | h<br>Day Year                   | 3. Time of Death                              |  |
| /ledi | ical Examii                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ner                                               | Fred Charles Sn                                                                                    | nith, <del>Sr.</del>                                |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | February 2                                   | 22, 2008                        | 0805 hrs                                      |  |
| Br.   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                   | 4a. Facility Name (if not institution, give st 11817 White Pine Drive                              | reet and number)                                    |                                       | 4b. City, Town, or<br>Hagerstown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | Death                                        | 4c. County of Dea<br>Washington |                                               |  |
|       | Funeral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                   | 5. Social Security Number 6. Sex                                                                   | 7. Age (In yr                                       | rs. last birthday)                    | If Under 1 Yea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | r If Under              | 24Hrs. 8. Date of Bir                        | th(MM/DD/YYYY) 9. I             | Birthplace (State or                          |  |
|       | Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ı                                                 |                                                                                                    | 2F                                                  | 49 Yrs                                | Months Day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | s Hours                 | Min.<br>May 27                               | , 1958 For                      | eign<br>Count(Y)<br>Mary Land                 |  |
|       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Į                                                 | Usual Residence of Decedent                                                                        | lan i                                               | St. T                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                              |                                 | 10d. Inside City Limits                       |  |
|       | w any                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | - 1                                               | 10a. State 10b. County                                                                             |                                                     | City, Town or Locat                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                              |                                 | 1 Yes 2 No                                    |  |
|       | daryland<br>28a-f show<br>1 at once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ъ                                                 | Maryland Washing                                                                                   | jton                                                |                                       | lagersto                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | wn                      |                                              |                                 |                                               |  |
| _     | //aryl<br>28a-1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Director                                          | 10e. Street and Number                                                                             |                                                     |                                       | 10f. Zip Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 1                                            | 0g. Citizen of What C           | ountry?                                       |  |
| 9     | ith the l<br>23a or<br>notifie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                   | 11817 White Pine                                                                                   | Drive                                               |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1740                    |                                              |                                 | SA                                            |  |
| 160   | ms 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | eral                                              | 11. Marital Status 1                                                                               | 2. Was Decedent Ever in<br>Armed Forces?            |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | n? (Specify Yes or No<br>Puerto Rican, etc.) | - 14. Race - Am<br>White, etc   | nerican Indian, Black,                        |  |
|       | death with the Maryland<br>or items 23a or 28a-f sho<br>must be notified at once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Funeral                                           | 1 Never Married 2 Married                                                                          | Yes 2 X N                                           | lo                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yes 2 XX No specify: Sp |                                              |                                 |                                               |  |
|       | 3 Widowed 4 Divorced If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                   |                                                                                                    |                                                     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                              | Specify: W                      |                                               |  |
|       | Mary 1 and Washington Hager stown  10e. Street and Number 10f. Zip Code 11g. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  12. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  15. Decedent's Education (Specify only highest grade completed)  16b. Kind of Busing Mary 1 and Washington 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Citizen of What 10g. Ci |                                                   |                                                                                                    |                                                     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                              | 16b. Kind of Busines            | SS/IIIQUSU y                                  |  |
|       | 71 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Elementary/Secondary (0-12)   College (1-4 of 5+) |                                                                                                    |                                                     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                              |                                 | Contractor                                    |  |
|       | 9 College (1-4 or 5+)  15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Social Occupation (CNO kind of Work doring 1988)  16. Decedent's Social Occupation (CNO kind of Work doring 1988)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                   |                                                                                                    |                                                     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | Name (First, Middle,                         |                                 |                                               |  |
|       | The standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard o |                                                   |                                                                                                    |                                                     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | etta Jean                                    | Conigliar                       | ~ó                                            |  |
|       | 21215<br>buld be file<br>Mental H<br>marked<br>ic event, t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 0                                                 | 19a. Informant's Name/Relationship (Type                                                           | e, Print )                                          | 19b. Mailin                           | g Address (Stre                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | et and Numi             | ber or Rural Route Nur                       | mber, City or Town, St          | ate, Zip Code)                                |  |
|       | O 성 전 := 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 7                                                 | Mary T. Smith - Wi                                                                                 | ife                                                 | 11817                                 | White R                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | oine D                  | r. Hagerst                                   | own, Mary                       | land 21740                                    |  |
|       | re, ML<br>s 1 and 2 s<br>of Health a<br>of item 27<br>iter traum                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                   | 20a. Method of Disposition                                                                         | 21                                                  | 0b. Place of Dispo<br>crematory or o  | sition (Name of ce                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | Date                                         | 20c. Location - City            | or Town, State                                |  |
|       | ages<br>nt of<br>t: If                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                   | 1 Burial 2 X Cremation 3                                                                           | Removal from State                                  | mithsburd                             | Cremato                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | orv F                   | eb.28,2008                                   | Smithsbur                       | rg, Maryland                                  |  |
|       | Baltimore,<br>permit. Pages 1 ar<br>Department of Her<br>Important: If ite                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1                                                 | 4 Donation 5 Other Specify.  21. Stringture of Funeral Servic License                              | 4 1                                                 |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Home, P.A.              |                                              |                                 |                                               |  |
|       | Balt<br>permit.<br>Depart<br>Import<br>injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                   | ( - 1)                                                                                             |                                                     | 425                                   | S. Cond                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ocoche                  | eaque St. W                                  | /illiamspor                     | -+, MD 21795                                  |  |
|       | Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                   | 23a. Part I. Enter the disease, or complicate failure. List only one cause on each                 | ations that caused the de                           | eath. Do not enter                    | the mode of dying                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | , such as ca            | ardiac or respiratory an                     | rest, shock, or heart           | Approximate Interval<br>Between Onset and     |  |
|       | /Medical<br>=xaminer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                   |                                                                                                    | cohol and Nar                                       | cotic (Meth                           | nadone. Mo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | rphine)                 | Intoxication                                 | 1                               | Death                                         |  |
|       | Adillilei                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                   | or condition resulting in death)                                                                   | e to (or as a consequen                             | ce of):                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                              |                                 |                                               |  |
|       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <u>_</u>                                          | Sequentially list conditions, if any, leading to immediate b                                       | e to (or as a consequent                            | ce of):                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                              |                                 |                                               |  |
|       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ij                                                | cause. Enter Underlying Cause                                                                      | e to to a some queri                                | 00 01,1                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                              |                                 |                                               |  |
|       | d sit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Examiner                                          | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): |                                                     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                              |                                 |                                               |  |
|       | cecuted<br>n and<br>- transit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                   | d                                                                                                  | AMENDED1, 23a,                                      | 27 28a-f                              | por MF a8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 77 3/20                 | /08 amh                                      |                                 |                                               |  |
|       | 760, icate be exerginate by physician the burial -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | edic                                              |                                                                                                    |                                                     |                                       | per rin go                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 77 3,20,                | , co canti                                   | 23d. Date of deli               | ven                                           |  |
|       | 8760, ificate be ag physicist he burns the burns and a street burns.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | n/M                                               | IF FEMALE:<br>23b. Was decedent pregnant in the                                                    | 23c. If yes, outcome of p                           | pregnancy<br>2 F                      | etal death 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Ectopic                 | pregnancy                                    | Month                           | Day Year                                      |  |
|       | Box 68  e death certifi  the attending  ed for use as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Physician/Medical                                 | past 12 months?                                                                                    | 4 Pregnant at time of                               | e                                     | ther (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                              |                                 |                                               |  |
|       | Bo<br>e deat<br>the at<br>ed for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | hys                                               | 1 Yes 2 No 9 Unknown                                                                               | 9 Unknown                                           |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | Tan nin                                      |                                 | to the course of death?                       |  |
|       | that th<br>ned by<br>detach                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | by P                                              | Part II. Other significant conditions c                                                            | ontributing to death but r                          | not resulting in the                  | underlying cause                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | given in Pa             |                                              |                                 | e to the cause of death?  Probably 4  Unknown |  |
|       | S, P                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | pe                                                |                                                                                                    |                                                     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 24a. Was                                     |                                 | e autopsy findings available                  |  |
|       | ords,<br>w requires been should                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | olet                                              |                                                                                                    |                                                     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | auto                                         |                                 | to completion of cause of                     |  |
|       | Pec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Completed                                         |                                                                                                    |                                                     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                              |                                 | Yes 2 No                                      |  |
|       | tal Rec<br>cian: The<br>certificate<br>ector, page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Be C                                              | 25. Was case referred to medical                                                                   |                                                     |                                       | 26.Plac                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | (Check only one)                             |                                 |                                               |  |
|       | Vit<br>hysici<br>this c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | To E                                              | 1 Yes 2 No                                                                                         | spital: 1 Inpatient 2                               |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Other <sub>4</sub>      | Nursing Home 5                               | Residence 6 C                   | Other: Scene                                  |  |
|       | fing Ph                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                   | 27. Manner of Death  1 Natural 5 Pending                                                           | 28a. Date of Injury<br>(Month, Day, Year)           | 28b. Time of                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ury at Work<br>Yes 2 🔀  |                                              | how injury occurred             |                                               |  |
|       | sion<br>ttend<br>death<br>ctor:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | atic                                              | 2 Accident Pending Investigation                                                                   | Found 2/22/0                                        |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | Unknown                                      | (Charat and Number o            | r Pural Pouto Number City                     |  |
|       | Division of Vital Records, P.O.  I or Attending Physician: The law requires that it after death.  II of rectors. After this certificate has been signed by it in by the funeral director, page 2 should be detacl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Certification:                                    | 3 Suicide 6 XX Could not be determined                                                             | 28e. Place of Injury -                              | At nome, farm, str                    | eet, ractory, onice                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | bullaling, et           | or Town,                                     | State) 11817 Whi                | r Rural Route Number, City<br>Lite Pine Drive |  |
|       | Dospit<br>hours<br>mers<br>y fill                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                   | 4 Homicide                                                                                         | 1                                                   | . 1 - 1                               | unuad at the atimes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | data and pla            | Hagersto                                     |                                 | hateta                                        |  |
|       | Livision of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely fill d in by the funeral director, page 2 should be detached for use as the burial - transi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ical                                              | one) 2 Medical Examiner: C                                                                         | n: To the best of my known the basis of examination | ion and/or investig                   | ation, in my opinio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | on, death oc            | curred at the time, date                     | e and place, and due            | to the cause(s)                               |  |
|       | To 1<br>To 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Medical                                           | 29b. Signature and title of certifier                                                              | nd manner stated.                                   | · · · · · · · · · · · · · · · · · · · |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | nse number              |                                              |                                 | (Month, Day, Year)                            |  |
| ,     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | _                                                 | Anota 11.                                                                                          | 1000                                                |                                       | O.C.M.E. February 23, 2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                              |                                 | 2008                                          |  |
|       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ,                                                 | 30. Name and address of person who co                                                              | moleted cause of death                              | (Item 23a)                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                              |                                 |                                               |  |
| 51    | 4-0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                   |                                                                                                    | Assistant Medical I                                 |                                       | 11 Penn Stre                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | et, Baltim              | nore, MD 21201                               |                                 |                                               |  |
| اميد  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | tate                                              | 31. Date filed (Month, Day, Year)                                                                  | 32. Registrar's Sig                                 | gnature                               | marks a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                              |                                 |                                               |  |
|       | Regis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                   | FEB 2 6 20                                                                                         | US Section                                          | o AM                                  | A STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PAR |                         |                                              |                                 |                                               |  |

Registrar

State

Baltimore,

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)